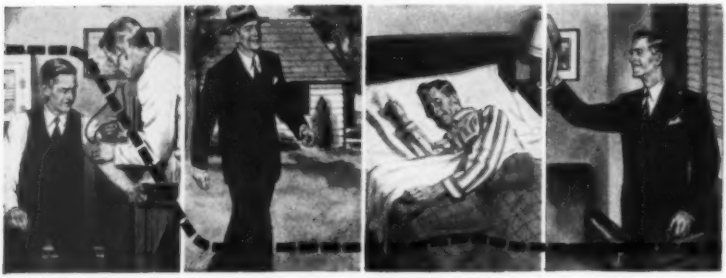
January **Medical Economics**

Ease the squeeze of taxes!

How?

See pages 66, 109, 161

Isn't this the picture you want to prescribe for your hypertensive patients?



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Medical Economics

* * * *January 1953* * * *

[CONTINUED ON FOLLOWING PAGE]

Contents *[Continued]*

DEPARTMENTS

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Corticotropin-gel
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prolonged therapeutic effects at reduced cost

new high potency **ACTH**
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LESS THAN 3⅓ CENTS PER UNIT OF CLINICAL ACTIVITY

The duration of the clinical effectiveness of this purified high-potency adrenocorticotropic hormone is greatly increased by the special repository menstruum. The initial therapeutic response is rapid and often lasts for 24 hours or longer. The high degree of purification of Corticotropin-Gel Wilson renders it relatively painless on injection and virtually free from untoward local or severe systemic reactions.

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Item 540—When administered intramuscularly or subcutaneously each cc. is clinically equivalent to 40 U.S.P. units of corticotropin.

$6.60 per vial of 200 units.

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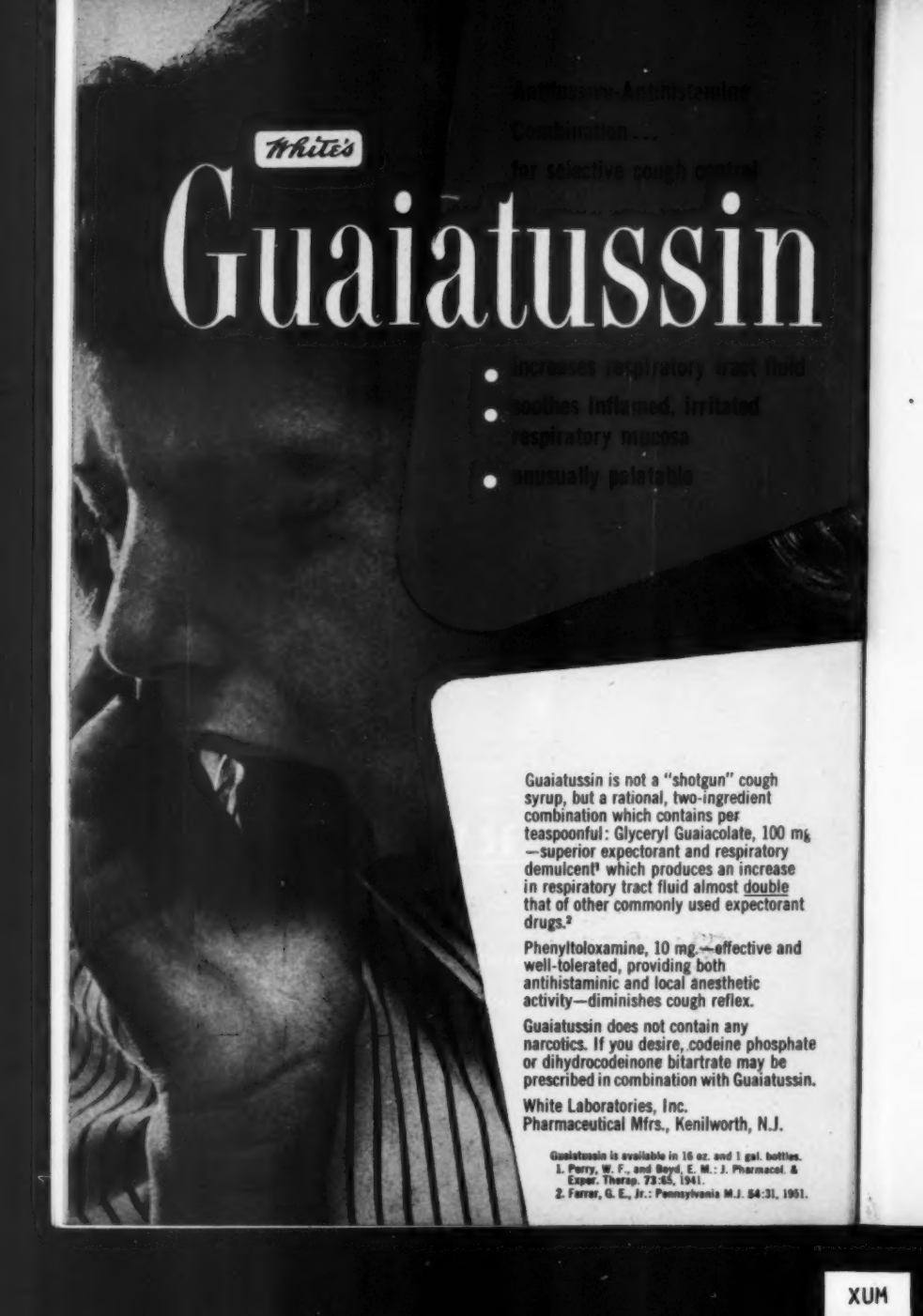
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Combination...
for selective cough control
increases respiratory tract fluid
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Guaiatussin is not a "shotgun" cough syrup, but a rational, two-ingredient combination which contains per teaspoonful: Glyceryl Guaiacolate, 100 mg.—superior expectorant and respiratory demulcent[1] which produces an increase in respiratory tract fluid almost double that of other commonly used expectorant drugs.[2]
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White Laboratories, Inc.
Pharmaceutical Mfrs., Kenilworth, N.J.
Guaiatussin is available in 16 oz. and 1 gal. bottles.
1. Perry, W. F., and Boyd, E. M.: J. Pharmacol. & Exper. Therap. 73:65, 1941.
2. Farrar, G. E., Jr.: Pennsylvania M.J. 54:31, 1951.

Panorama

The battle to bar osteopaths from the municipally owned Bay City (Mich.) General Hospital ended in a victory at the polls. Some 20,000 citizens voted nearly three to one against letting the D.O.'s practice there . . . American Journal of Nursing now refuses nurse-wanted ads from hospitals with sub-standard pay and working conditions . . . Convicted of defrauding a health insurance company by padding patients' claims, a Minnesota physician has been given six months in which to repay some $13,000.

Is overproduction causing boom prices of antibiotics to go bust? Business analysts see signs of price-cutting in Standard & Poor's stock index, with ethical drug sales going up, profits down . . . M.D.-members of the American Public Health Association find themselves outnumbered by non-M.D. members. So they're talking about forming an American Association of Public Health Physicians . . . Bait to lure better-trained physicians into mining regions of Kentucky, Virginia, and West Virginia: ten new hospitals sponsored by the United Mine Workers . . . Medical schools got nearly $3 million in 1951 and 1952 from the National Fund for Medical Education. Executive Director Chase Mellen Jr. says the fund's annual collection goal may be raised from $5 million to $10 million.

Office signs were ethically under control, the New York County medical society thought, with restrictions on the size of letters used. Then it found—and rebuked—a member who had an ethical-size sign on each of his nine office windows . . . To insure patients' bed rest at home, the woman's auxiliary of the Union County (N.J.) Medical Society now sponsors a squad of trained "homemakers." For $1.25 an hour, homemakers tend children, cook meals, run errands—but do no nursing.

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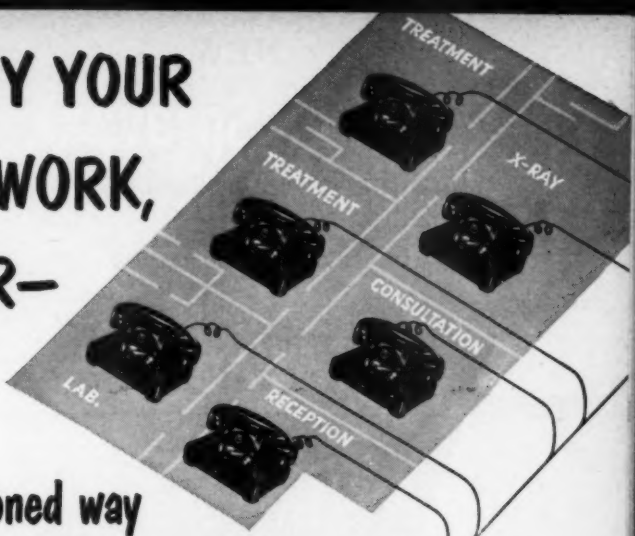
in the new fashioned way —and enjoy better medical records!



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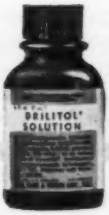

'Drilitol Spraypak' combines the superior intranasal coverage of a spray from a full-sized atomizer with the economy of a nose-drop bottle.

'Drilitol Spraypak' covers the nasal mucosa—in a fine, even mist.

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'Spraypak' Trademark

for intranasal infections

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†T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F.

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Take table silver: Sterling is the best—silver all the way through—not just plated on the outside.

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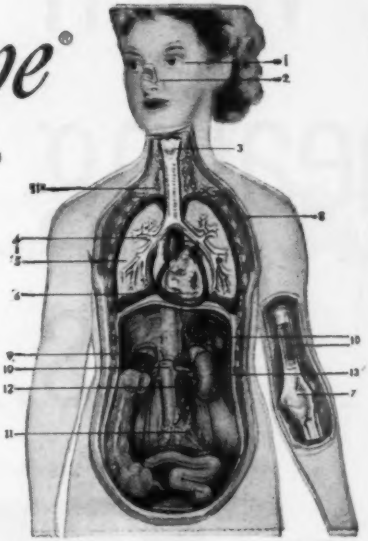

The many indications for CORTONE *highlight its therapeutic importance in everyday practice*

Primary Site of Pathology and Indications

1. EYE—Inflammatory eye disease. **2. NOSE**—Intractable hay fever. **3. LARYNX**—Laryngeal edema (allergic). **4. BRONCHI**—Intractable bronchial asthma. **5. LUNG**—Sarcoidosis. **6. HEART**—Acute rheumatic fever with carditis. **7. BONES AND JOINTS**—Rheumatoid arthritis; Rheumatoid spondylitis; Acute gouty arthritis; Still's Disease; Psoriatic arthritis. **8. SKIN AND CONNECTIVE TISSUE**—Pemphigus; Exfoliative dermatitis; Atopic dermatitis; Disseminated lupus erythematosus; Scleroderma (early); Dermatomyositis; Poison Ivy. **9. ADRENAL GLAND**—Congenital adrenal hyperplasia; Addison's Disease; Adrenalectomy for hypertension, Cushing's Syndrome, and neoplastic diseases. **10. BLOOD, BONE MARROW, AND SPLEEN**—Allergic purpura; Acute leukemia† (lymphocytic or granulocytic); Chronic lymphatic leukemia.† **11. LYMPH NODES**—Lymphosarcoma†; Hodgkin's Disease†. **12. ARTERIES AND CONNECTIVE TISSUE**—Periarteritis nodosa (early). **13. KIDNEY**—Nephrotic Syndrome, without uremia (to induce withdrawal diuresis). **14. VARIOUS TISSUES**—Sarcoidosis; Angioneurotic edema; Drug sensitization; Serum sickness; Waterhouse-Friderichsen Syndrome.

†Transient beneficial effects.

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Speaking Frankly

Surgeons

SIRS: I just read your report on the wrangle between the American College and the International College of Surgeons.

I'm a member of the American College. I've always regarded the International College as being a bit second-rate. But let's put some of the blame where it belongs:

For years, the A.C.S. was asleep at the switch. It spent most of its time and money on its hospital standardization program, letting the needs of the individual surgeon go hang. The I.C.S., on the other hand, recognized that these needs existed, and took steps to capitalize on them.

To give local surgeons a medium of expression, it set up state chapters. These have been active in a big way. The surgeons have been enthusiastic about them. Now, at long last, the A.C.S. is beginning to form state chapters too.

All this is nothing but a repetition of the old familiar story: An organization is born, it develops into vigorous adulthood, then its arteries harden and it deteriorates. If a competitor appears on the scene, either the established outfit revitalizes to meet the challenge, or it folds up, or it keeps going on a reduced scale.

More and more, the A.C.S., like the American College of Physicians, seems destined to become an exclusive "club"—a nice organization to belong to but one with little real potency. Meanwhile, the not-at-all-exclusive I.C.S. will increase its ranks as long as there are surgeons who can't make the A.C.S. and who want a certificate to hang on the wall to feed their egos and to impress their patients.

M.D., New Jersey

Tax Books

SIRS: Can you suggest a few publications that would give me detailed help in making out my income tax form?

M.D., Montana

In addition to the many tax articles published regularly in MEDICAL ECONOMICS, *there are several other valuable sources of information. One of the most authoritative, of course, is* YOUR FEDERAL INCOME TAX, *an annual publication of the Bureau of Internal Revenue. It can be bought for 25c from the Superintendent of Documents, Washington 25, D.C.*

Other useful books include:

DOCTOR'S AND DENTIST'S TAX HANDBOOK. *By Paul Gitlin. New York: Prentice-Hall, Inc.* [MORE→

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THERAPEUTICALLY CORRECT

ACE® *full-footed elastic hosiery for men*

For men requiring support of leg structures, ACE Elastic Hosiery fulfills all the requirements for a better therapeutic hose: not only are they medically correct, but they are also smart looking and comfortable to wear. ACE Full-Footed Elastic Hosiery for Men resembles regular nylon dress hose — men who are particular about their appearance will be proud to wear this distinctive, burgundy colored hose. No overhose are required.

B-D's exclusive weaving process makes possible the introduction of this full-footed elastic hose. Woven of a firm but lightweight latex and nylon, ACE Elastic Hosiery for Men provides gentle but persistent support to the entire venous tree.

BECTON, DICKINSON AND COMPANY, RUTHERFORD, N. J. B-D

YOUR INCOME TAX. *By J. K. Lasser. New York: Simon and Schuster*

LASSER'S BUSINESS TAX HANDBOOK. *By J. K. Lasser. New York: Simon and Schuster*

PHYSICIANS' FEDERAL INCOME TAX GUIDE. *By James B. Liberman and Hugh J. Campbell. Great Neck, N.Y.: Doniger and Raughley*

A monthly bulletin called "The Doctor's Tax Letter" is published at 2000 North Lincoln Park West, Chicago 14, Ill.

Malpractice Disclaimer

SIRS: In your November article, "Uniform Malpractice Rates—At Last," the name of Liberty Mutual is included in a list of companies writing malpractice insurance. This is in error.

Liberty Mutual does not write malpractice insurance and does not contemplate doing so in the immediate future.

William Doyle, Vice President
Liberty Mutual Insurance Co.
Boston, Mass.

'Pitiable Creatures'

SIRS: The article "Doctors' Wives Are a Problem" proves that its author, Dr. Kaufman, is a keen observer. I've been a doctor's wife for eighteen years. So I can sincerely sympathize with any physician who has one of us pitiable creatures for a patient.

It just isn't logical for us to be ill, is it? Apparently, it isn't ethical either. I feel so sorry for my husband when he has to call a doctor for me and waste his valuable time describing my "neurotic" symptoms—as *he* sees them, of course, not as *I* feel them.

How can an otherwise intelligent group of men so consistently choose such emotionally unstable partners?

M.D.'s Wife, California

Administrative M.D.'s

SIRS: The article on administrative medicine by Barton Lawden, M.D., was most interesting. But it didn't answer one question: How does a doctor get into this field?

I'd like to know how to acquire the necessary educational background, and how to make contacts with organizations in need of medical administrators.

John M. Perry Jr., M.D.
Oklahoma City, Okla.

Courses in hospital administration and public health administration are offered by the graduate departments of a good many medical schools and by the American Hospital Association in Chicago. Dr. Lawden suggests the following ways to break into the field:

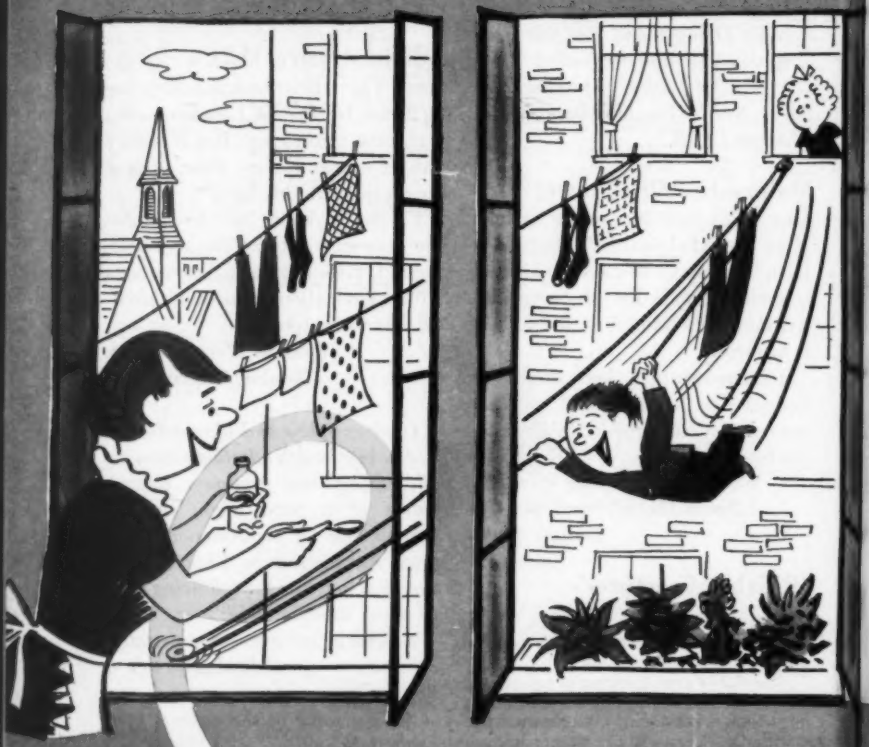
¶ Offer to serve on administrative committees of medical societies or hospitals.

¶ Take some of the courses mentioned above, thus establishing contact with colleagues and instructors.

¶ Join the V.A. or the Public Health Service for a sampling of administrative work.

¶ Get a job with a large pharmaceutical house, either by writing di-

He's heard the co



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POUR out a shimmering spoonful of VI-DAYLIN . . . notice its unclouded yellow-honey appearance . . . sniff its pleasant, citrus-like odor . . . then *taste* it! That delicious lemon-candy flavor explains why children accept VI-DAYLIN eagerly right from the spoon—and willingly come back for more.

NOW CONTAINS 3 TIMES THE B_{12}

But take a look at VI-DAYLIN's improved formula. Here, truly, is effective multivitamin therapy. Seven important vitamins in every spoonful—and now three times as much vitamin B_{12}. One 5-cc. teaspoonful daily is the average dose for children up to the age of 12. Mixes with milk, juices and soft foods for infants. Stable without refrigeration. VI-DAYLIN is available at all pharmacies in 90-cc., 8-fluidounce and 1-pint bottles.

Abbott

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Each 5-cc. teaspoonful of VI-DAYLIN contains:

Vitamin A	3000 U.S.P. units
Vitamin D	800 U.S.P. units
Thiamine Hydrochloride	1.5 mg.
Riboflavin	1.2 mg.
Ascorbic Acid	40 mg.
Vitamin B_{12} Activity (by microbiological assay)	3 mcg.
Nicotinamide	10 mg.

rectly to the medical service department or by applying through physician-placement agencies.

¶ Direct inquiries to health, accident, or life insurance companies. This may lead to such work as checking disability claims, which in turn may lead to an administrative appointment.

Aide's Complaint

SIRS: Too few doctors really know anything about appointment scheduling, bill collecting, office equipment needs, and office costs. Many a well-trained medical secretary is frustrated in her attempt to run the office smoothly, because of her employer's lack of understanding and cooperation.

So why don't the medical schools include training in business management as a required course for future M.D.'s?

M.D.'s Aide, Texas

Tax on Royalties

SIRS: During 1952 I had some royalties from the publication of my medical textbook. A court decision cited in one of your news items leads me to believe I can treat such income as a long-term capital gain. May I?

M.D., Pennsylvania

The writer of the news item in question [September, 1952, page 262] failed to dig deeply enough. The book under consideration was sold in 1945, when the law permitted proceeds of the outright sale of literary compositions by non-professional writers to be classed as capital gains. Under the Revenue Act of 1951, this is no longer possible. As for royalties: They are and always have been classed as ordinary income, not capital gain.

Hospital Hitlers

SIRS: The anonymous writer of the pamphlet described in your article, "'Hitlers in Our Hospitals,'" evidently has a grudge against one hospital administrator. The truth is that about 98 per cent of medical men are probably satisfied with their hospital affiliations.

By and large, the administrators are extremely able individuals. They're versatile, and they usually have excellent business backgrounds as well as natural acumen. Otherwise, they couldn't keep their jobs.

C. L. Mulfinger, M.D.
Los Angeles, Calif.

Adoptions

SIRS: I realize that you like to present controversial topics as a kind of stimulus to readers. And with the article, "If They Want to Adopt a Child," by Otto F. Reiss, you certainly managed to stimulate *me*. In short, I strongly disagree with the author's point of view.

It all seems to boil down to the contention that a social worker, using a lengthy questionnaire, can secure more valuable information to take back to her almighty council of welfare directors than a doctor who has known a couple of families intimately for years. By means of such

questionnaires, the august, all-wise council can presumably match up parents and child perfectly. So perfectly, in fact, that the arrangement works out better than if these same parents were to have a child of their own!

Let's face it: The adoption agencies have sold us and the lawmaking authorities a bill of goods. They say that we doctors can't understand human nature and evaluate the emotional reactions of a childless couple or an unwed mother. And because *they* say so, the law in most states agrees with them. So that makes it official.

The truth is that the doctor is the *only* logical person to get the parties together—anonymously, of course. The lawyer alone should take care of the legal aspects of an adoption; and only the judge can see to it that the rights of all parties are protected.

Originally, social agencies were called in to collect information that would help judges fulfill their obligations. This they can do. This they should be permitted to do. But no more.

We doctors should wake up. Let us seek repeal of the laws that give social agencies the monopoly they now have over all matters concerning adoption.

Elgin P. Kintner, M.D.
Maryville, Tenn.

SIRS: Your article, "If They Want to Adopt a Child," paints a glowing —but not quite true—picture of the work of the adoption agencies. In

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Left back

Applied	Removed	Result
-28-51	9-30-51	Negative
-28-51	9-30-51	Negative
-28-51	9-30-51	Negative
-30-51	10-1-51	Negative
-28-51	9-30-51	Negative
-28-51	9-30-51	Negative
-28-51	9-30-51	Negative
-28-51	9-30-51	Negative
10-6-51	10-7-51	Negative
-28-51	9-30-51	Negative
-28-51	9-30-51	Negative
9-28-51	9-30-51	Negative
9-28-51	9-30-51	Negative
9-28-51	9-30-51	Negative
9-28-51	9-30-51	Negative
9-28-51	9-30-51	Negative
9-28-		
9-28-		
9-28-		
9-28-		
10-3-		
9-28-		
10-3-		
9-28-		
9-30-		
9-28-51		Negative
9-30-51	10-1-51	Negative

11 Provocative Test

Right wrist - dorsal

Applied	Removed	Result
10-14-51	10-17-51	Negat
10-14-51	10-17-51	Negat
10-14-51	10-17-51	Negat
10-15-51	10-18-51	Negat
10-14-51	10-17-51	Negat
10-14-51	10-17-51	Negat
10-14-51	10-17-51	Negat
10-14-51	10-17-51	Negat
10-21-51	10-24-51	Negat
10-14-51	10-17-51	Negat
10-14-51	10-17-51	Negat
10-14-51	10-17-51	Negat
10-14-51	10-17-51	Negat
10-14-51	10-17-51	Negat
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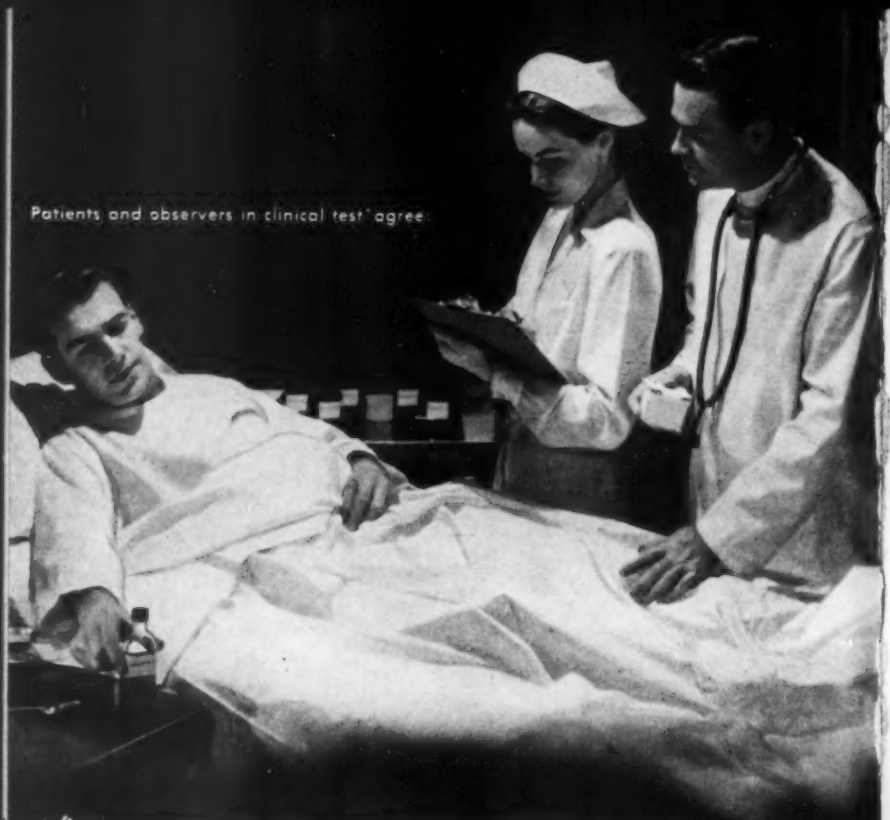

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*Cass, L. J. and Frederik, W. S.: Am. Pract. and Digest of Treat., 2:844, 1951. Report of blind test on 22 hospitalized patients.

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the last eight years I've known seven families who have tried to adopt children. Each has had to wait more than two and a half years for a child. And anonymity is *not* preserved; parents learn the name of the mother and often the father when the legal papers pass.

I can see some legal advantages in the present methods. But the general practitioner of twenty or thirty years ago did a better job of protecting the child's interests than the social worker does now.

Of course, times have changed, and the physician is no longer so intimately acquainted with his patients as he used to be. So it's probably not feasible for him to handle adoptions. But the agencies should realize that they have a long way to go in social and public relations, in spite of their extensive facilities for dealing with the problem.

M.D., Michigan

Blue Shield Fees

SIRS: According to a recent MEDICAL ECONOMICS article, "an estimated 70 per cent of all Blue Shield plans pay only one fee for surgery . . . the surgeon has to collect the insurance benefits and divide them with his assistant. Technically, this is fee splitting."

The Rhode Island Medical Society Physicians Service has a simple answer to this. It provides for direct payment of an assistant surgeon's fee and an anesthetist's fee, on a sliding scale based on the surgical indemnity.

Each doctor gets a voucher showing the operation performed and the amount he is to receive for his services. What's more, a carbon copy of that voucher is sent directly to the patient. Thus he knows who the surgeon, the assistant, and the anesthetist were, and how much each of them was paid for services rendered.

Charles L. Farrell, M.D.
Pawtucket, R.I.

Medical Testimony

SIRS: According to a recent Newsvane item, Lawyer Robert E. Coughlan Jr. blames doctors for miscarriages of justice caused by their false testimony. In my opinion, the greatest miscarriage of justice comes about because lawyers or judges impose such strict limitations on the physician's testimony.

I have testified in only a few cases where every effort was made to bring out *all* factors that had bearing on the case. In most instances, the judge allowed me to answer questions with only a "Yes" or "No."

Plainly, then, the court findings in, say, a compensation case depend on the ability or limitations of the lawyers arguing the question, and *not* on the medical testimony.

Jacob Segura Jr., M.D.
Mansfield, La.

Verdant Florida

SIRS: I hate to disillusion the Ohio doctor who recently protested that Florida doctors are charging from $20 to $30 for house calls. But he seems to be judging the whole pro-

fession by a few exceptional cases. During a year of practice in Miami, I've found that the average charge for home calls is $5—maybe as high as $10, if injections are given. In my opinion, Miami's fee schedule would compare favorably with that of any other city of similar size.

M.D., Florida

SIRS: We do have an infinitesimal number of predatory artists here who charge $30 for a house call; they're a disgrace to the profession. But even more distressing is the visiting M.D. who, while basking in the sun, disparages local physicians who are working hard to make ends meet.

Herman G. Rosenbaum, M.D.
Miami Beach, Fla.

Doctors vs. Nurses

SIRS: Not long ago, you published a letter deploring a popular magazine's photograph of an Army field hospital in Korea. The writer complained because the nurse in the picture outranked the doctor and was given five lines of print, while the M.D. was "barely mentioned."

This letter is a disgrace to the profession. It was written, I presume, by someone who never read Osler's comment on the choice between a good nurse and two fairly good doctors.

Any wounded G.I. will tell you that it's the nurse, not the doctor, whom he remembers. Military rank? Nuts! Most nurses should be five-star generals. And I know a couple of medical men who couldn't be buck privates in *my* book.

M.D., New York

Tax Proposal

SIRS: Why shouldn't physicians be permitted to make "amortization" deductions in their tax returns, to recover the cost of their professional education? Let me explain what I mean:

To begin with, at a conservative estimate, the cost of a doctor's education—including *only* medical school tuition, books, and instruments—amounts to something over $5,000. Also, on his graduation from medical school, a 25-year-old doctor has a life expectancy of 43.5 years—and he'll probably continue to practice till he dies. So let's divide the approximate cost of education by the number of years of practice; the quotient comes to about $115.

Logically, as I see it, this figure should be deductible annually on the doctor's income tax return. (And later expenditures for post-graduate or refresher courses should, of course, be treated in the same way.) In this fashion, the doctor would be "amortizing" his education cost by means of tax deductions.

That sounds reasonable, doesn't it? Yet it can't be done under present tax laws.

As the Internal Revenue Code now stands, a taxpayer can recover, through depreciation or amortization deductions, only the amounts he has invested in property used for the production of income. But

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"property" doesn't mean simply tangible physical property. It means intangibles as well (leaseholds, patents, and copyrights, for example).

The question is: Can the knowledge and skills the physician acquires through years of study also be considered property? The logical answer: yes.

From the economic viewpoint, there's no reason why a physician or other professional person should be treated differently from a businessman. The businessman must invest in physical equipment before he starts producing goods or services and earning income. The physician makes a comparable investment in acquiring the knowledge and skills to be used in carrying on *his* work. As Mr. Justice Cardozo once said, learning is "akin to capital assets."

It's apparent, then, that professional men with expensive educations would stand to gain by a change in the present rule.

Only an investment in property as now *restrictively* defined may be amortized in taxes. But there's good reason for redefining the word "property."

The Joint Committee on Internal Revenue Taxation (Room 1011, New House Office Building, Washington, D.C.) has invited suggestions for improving the tax laws. It is interested in such matters as this one. So physicians and their organizations might profitably accept the committee's invitation.

Albon P. Man Jr., LL.B.
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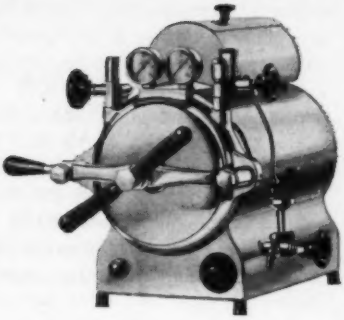

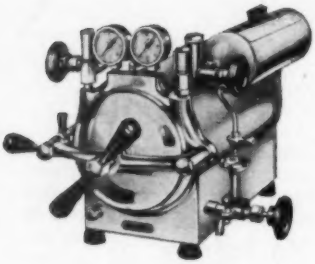

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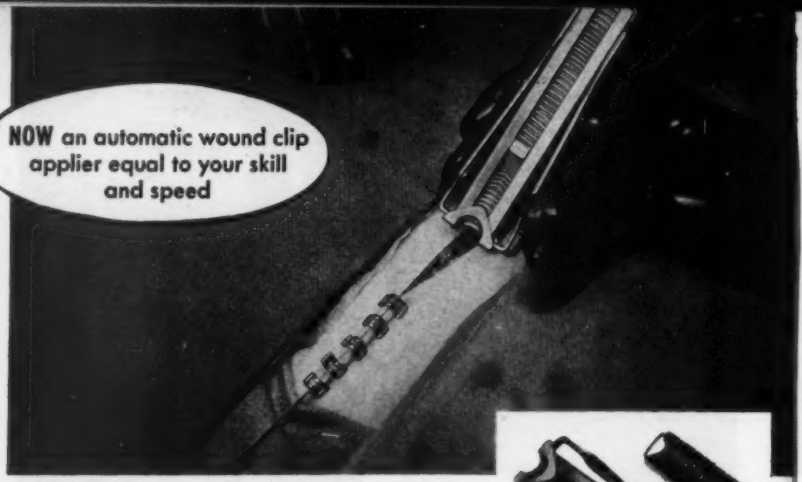

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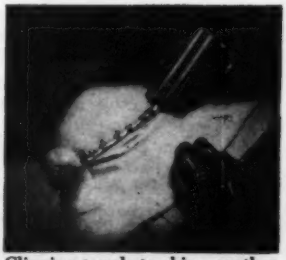

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1. Heimer, C. B., Grayzel, H. G. and Kramer, B.: Archives of Pediat. 68:382, 1951.
2. Behrman, H. T., Combes, F. C., Bobroff, A. and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

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1. Dennison, A.D.: *Jour. Med. Soc. New Jersey*, 46:119, Mar., 1949.
2. Sulzer, M.S.: *Jour. Florida Med. Assn.*, 34:637, May, 1948.

Sidelights

On Flaunting Prosperity

"Is Your Prosperity Showing?" asked an editorial in this magazine a while ago. It mentioned some of the habits a doctor can fall into—habits that make people think a life of luxury is the latter-day M.D.'s No. 1 aim.

The editorial cited several examples. Since then, we've run across quite a few more. The habits they illustrate may not be bad in themselves; but they're often indulged at the wrong time. To wit:

¶ A doctor rushed through several weeks' worth of patients in one week, billed them immediately—then took off for Florida. Not long after the bills reached his patients, so did the weekly home-town newspaper. On its society page, the townspeople could mull over a three-column cut of the doctor and his wife lolling on a beach—the caption explaining that they were spending a month at one of Florida's best known (and most expensive) hotels.

¶ Another physician customarily dictates personal mail with his consultation-room door ajar. While patients cool their heels in the anteroom, they can thus savor the doctor's plans for golf dates, club dinners, and week-end outings.

¶ A dozen physicians in a medium-size community have taken to dining together once a month. Their public relations are not enhanced by the shiny row of Cadillacs—all identifiable as doctors' cars—parked outside the plushiest eatery in town.

Certainly, no one wants the physician to be a hypocrite. Yet a little thought ahead of time can often forestall a lot of ill-feeling later.

Free Drinks at 95?

According to the Seventh MEDICAL ECONOMICS Survey, more than half the country's independent physicians don't want to be covered by Social Security. This apparently means that they'd rather not have the Government take a hand in their old-age planning.

We now wonder what would have happened if we'd asked them to comment not on the Government's plan but on the McGeachy Plan.

In case you don't know it already, this plan is the brain child of a Canadian newspaper editor, J. H. McGeachy. And it's based on "the well-known psychological fact that a glass of whisky means a great deal more to a 20-year-old than it does to a 50-year-old."

The McGeachy old-age assistance scheme calls for a graduated tax on

whisky, inversely correlated with the age of the drinker. A 20-year-old, for example, would pay 75 cents, tax included, for a shot of Old Panther Hiss. A nickel would be chopped off the price every five years after that.

Under his system, says McGeachy, you'd be drinking free at 95. "Think how much better it would be than Social Security," he says, adding without risk of denial: "*That* would *really* give you something to look forward to in your old age."

Liquid Assets

Also in a spiritual vein (although perhaps more practicable) is this investment tip from Business Week:

There's money to be made in wine —if you buy and store it carefully.

"Right now," it says, "the great 1947 vintage of European wines is in reasonably good supply; prices are low. But five years from now, prices are likely to be up about 25 per cent."

To get into the act takes only capital, a superficial knowledge of good wines, and a suitable place to store them. One foresighted investor has allegedly gone so far as to rent part of a warehouse to hold his stock. But for the average doctor, almost any cool, dry space will do.

What wines should you stock? Among the 1947 vintages, Bordeaux and Burgundy are cited as good bets. Other great vintage years: 1945, 1948, and 1949 for the German Rhines and Moselles.

But what if, for some reason, the

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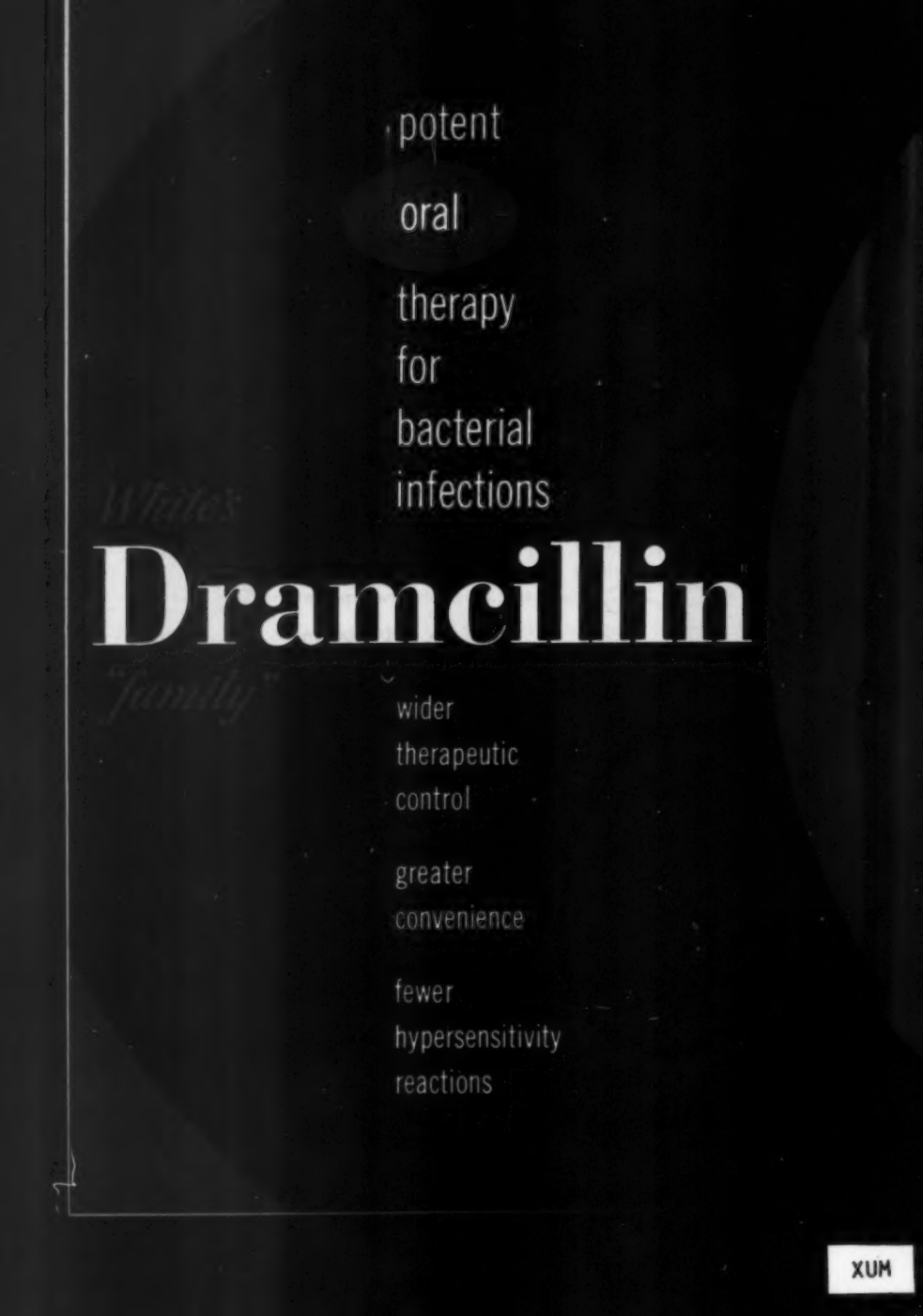
'Vi-Mix Drops'

(MULTIPLE VITAMIN DROPS, LILLY)


potent
oral
therapy
for
bacterial
infections
Dramcillin
wider
therapeutic
control
greater
convenience
fewer
hypersensitivity
reactions

expected rise in price doesn't materialize? In that case, the magazine points out, you'll at least enjoy liquidating your investment.

Introductory Bonus

From Winston-Salem's Dr. Wingate Johnson, who knows his physician-patient relations, comes this advice:

Let the medical man try to set aside at least an hour for the first consultation with a new patient. And let him use this time for taking a complete history and making a thorough examination.

This is advice with a two-way stretch: It applies equally well to the established man who's swamped with patients and to the young one who's struggling to build up a practice.

The established practitioner, as Dr. Johnson points out, finds it really a time-saver in the long run. For when he checks the patient thoroughly at the first visit, he's off to a flying start at later visits.

And the younger doctors who may have more time than patients on their hands? For them, Dr. Johnson makes this common-sense point: An unhurried examination is the best possible way to convince a new patient that you do thorough work.

Dollar Doctor

An enterprising Midwesterner has come up with a new idea for medical fees—an idea that is breath-taking in its simplicity. You set all fees at $1, then publicize them widely

PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

Avoidance of **ANOREXIA** in the second year

Early Self Feeding By Infants

NEXT TO respiratory infections, anorexia is the most frequent single complaint to physicians regarding children in their second and third year. Most commonly, we find this anorexia due to emotion rather than disease. And we have learned that avoidance of insistence on a prescribed dosage of food in the "demand feeding" technique reduces the frequency of this complaint.

● **Another technique,** often not sufficiently emphasized, is early self feeding. The mother may regard the first infantile attempts as annoying, interfering with her efficiency in getting food into her child's stomach. But she can easily be taught that a messy face and bib, an untidy kitchen, is a price soon repaid. As we physicians well know, it is quite possible for a baby at eight or nine months to feed himself completely except for assistance with his milk. Bits of toast or bread are convenient conveyors for other foods such as chopped meats, hamburger, and apple sauce. Hands were used long before spoons. The first sign of independence in eating should be encouraged, because we know that many cases of habitual anorexia can be avoided if the child is allowed not only to choose how much he wants, but also to convey it into his mouth with his own technique.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and will appear monthly in Medical Economics.

through handbills given away on the street.

This is no pipe dream. He's actually doing it, and we've just recently come across one of his handbills. Naturally, it's the size and shape of a $1 bill; but its couple of hundred words of text are considerably more provocative than *E Pluribus Unum*.

The Dollar Doctor's Medical Clinic, we are told, has "$20,000 invested in modern equipment." Its "low prices are based on large volume," and its best reference is "over 12,000 satisfied patients." What's more, it offers to treat anything from blood disorders to "itching of privates," from diabetes to "poor stream"—all at $1 a throw.

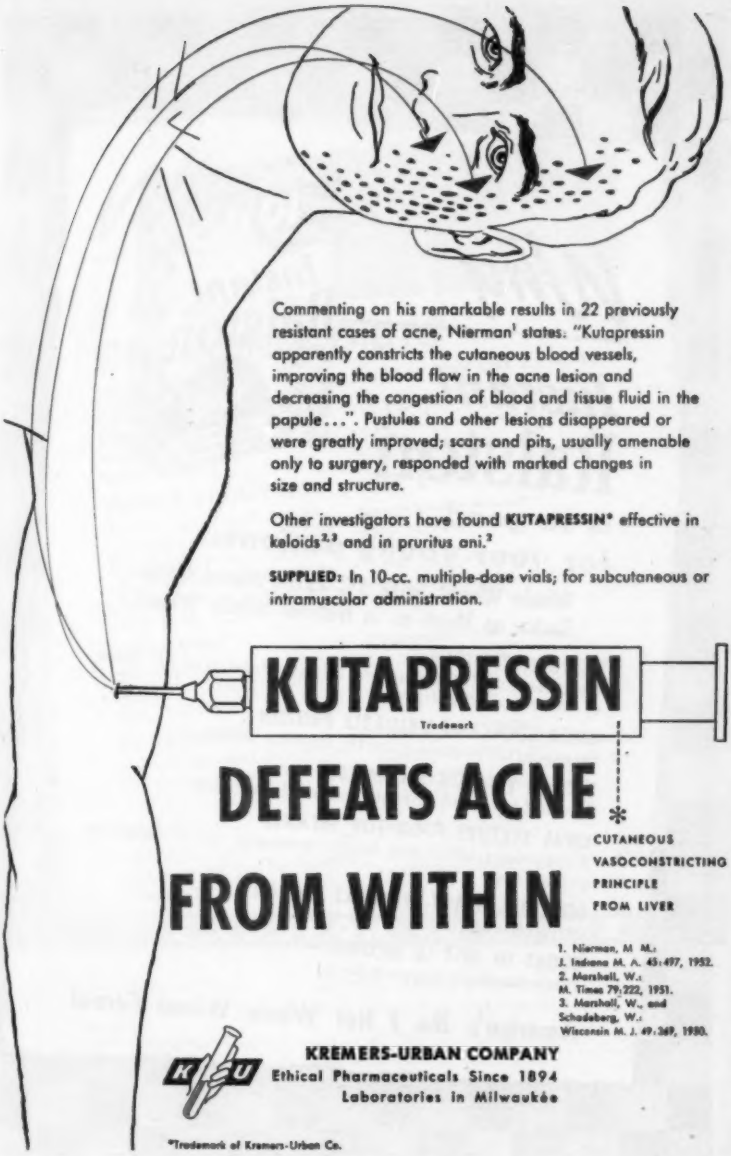
Excerpts from the fee schedule: "CORRECT DIAGNOSIS: Complete history, thorough examination, laboratory, and X-ray. Eye, $1; Ears, $1; Nose, $1; Throat, $1; Heart, $1; Abdomen, $1; Rectal, $1; Female Disease, $1; Male Disease, $1 . . . "

Treatment fees are computed separately and carried out to the last decimal place. As witness: "Stomach complaints, $1; Rectal complaints, $1; Feet complaints, $1; Heart disease, $1; High blood pressure, $1; Nervousness, $1 . . . "

Who is this man who has magically brought order to the medical fee system? Is he chiropractor, naturopath, or sanipractor?

Not a bit of it. He's a full-fledged M.D. who, at last report, still practiced in an approved hospital.

E Pluribus Unum! Which we translate to mean: It takes all kinds!



Commenting on his remarkable results in 22 previously resistant cases of acne, Nierman[1] states: "Kutapressin apparently constricts the cutaneous blood vessels, improving the blood flow in the acne lesion and decreasing the congestion of blood and tissue fluid in the papule . . .". Pustules and other lesions disappeared or were greatly improved; scars and pits, usually amenable only to surgery, responded with marked changes in size and structure.

Other investigators have found **KUTAPRESSIN*** effective in keloids[2,3] and in pruritus ani.[2]

SUPPLIED: In 10-cc. multiple-dose vials; for subcutaneous or intramuscular administration.

KUTAPRESSIN

Trademark

DEFEATS ACNE FROM WITHIN

* CUTANEOUS VASOCONSTRICTING PRINCIPLE FROM LIVER

1. Nierman, M. M.: J. Indiana M. A. 45:497, 1952.
2. Marshall, W.: M. Times 79:222, 1951.
3. Marshall, W., and Schadeberg, W.: Wisconsin M. J. 49:369, 1950.

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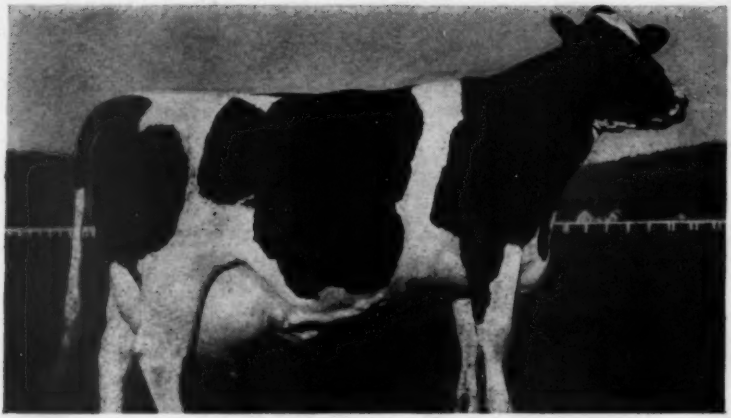


How this Great Champion Helps Protect Your Recommendation of Carnation . . .

MEET CARNATION HOMESTEAD DAISY MADCAP—one of the many world champion cattle bred at the famous Carnation Farms near Seattle. Cattle from these prize bloodlines go to dairy farmers throughout the country to improve the quality of Carnation's local milk supply *...and thus help protect your recommendation of Carnation.*

Carnation Gives Your Recommendation this

5-WAY PROTECTION

1. Carnation accepts only high quality milk for processing. Carnation Field Men regularly check local farmers' herds, sanitary conditions and equipment—reject any milk that does not meet Carnation's high standards.

2. Carnation processes ALL milk sold under the Carnation label. From cow to can it is processed with prescription accuracy in Carnation's *own* plants under its *own* supervision.

3. Carnation quality control continues even AFTER the milk leaves the plant. To be sure of freshness and highest quality, Carnation salesmen use a special code control in making frequent inspection of dealers' stocks.

4. Carnation Milk is available everywhere. Mothers can find Carnation Milk in virtually *every* grocery store in *every* town throughout America.

5. Cattle bred from champions like the one shown above are distributed to local dairy farmers to improve the quality of the milk supplied to Carnation plants.

DOUBLE-RICH in the food values of whole milk.

FORTIFIED with 400 units of Vitamin D per pint.

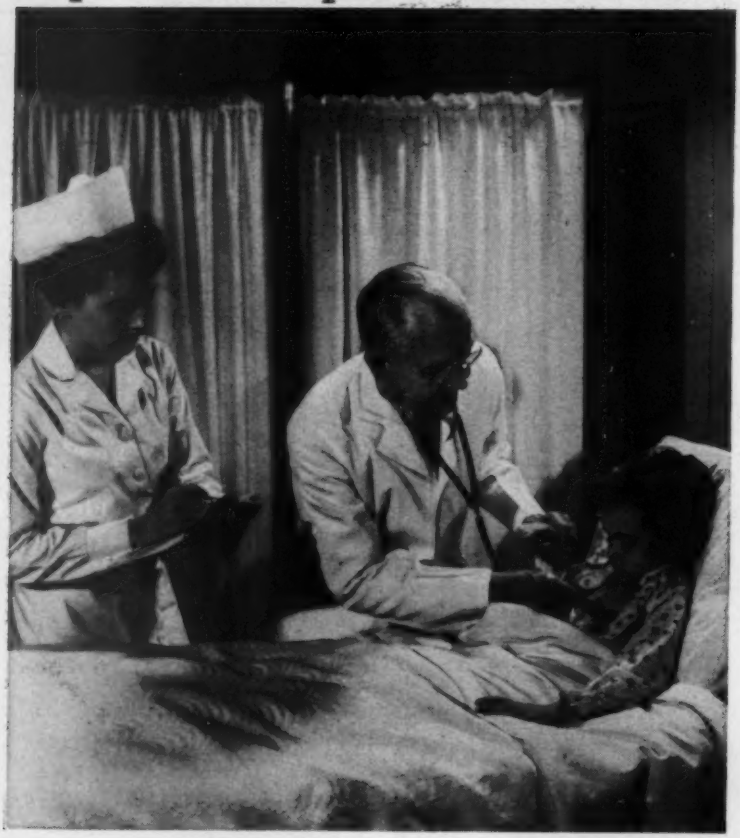
HEAT-REFINED for easier digestibility.

STERILIZED in the sealed can for complete safety.

"The Milk Every Doctor Knows" **"from Contented Cows"**

Preference for

Expressed in panel discussion:[1]



Except for the most severe infections, oral penicillin, in the form of PENALEV *Tablets, "eliminates the needle" in treating bacterial pneumonia, tonsillitis, scarlet fever and many other bacterial diseases in both children and adults.*

1. Panel Discussion, Pennsylvania M.J., *55*:42, Jan., 1952

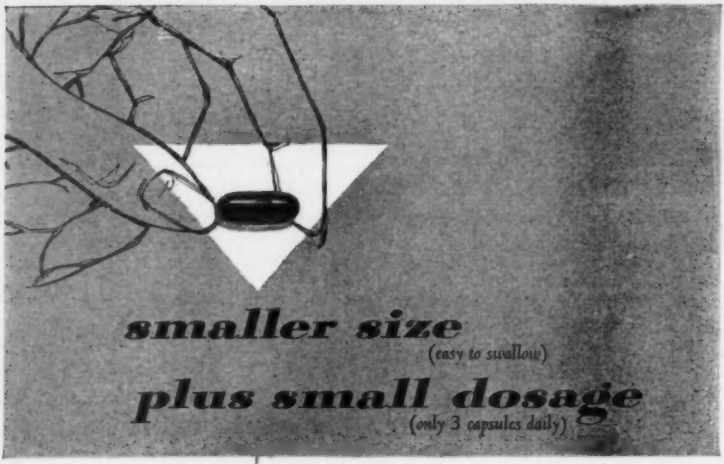
Oral Penicillin

A highlight of the 101st Annual Session of the Medical Society of the State of Pennsylvania was a panel discussion of the more important new drugs used in internal medicine.

Initially, the discussion centered around the treatment of bacterial pneumonia with various antibacterials. One of the panel members remarked that "we give penicillin by mouth . . . we prefer to give it by mouth."[1] Other panel members were in agreement that penicillin is the drug of choice. "The temperature responses in the various groups (given other, costlier antibiotics)—illustrate the point that oral penicillin is as effective . . ."[1]

Less Sensitivity With Oral Penicillin?

There is now no question of the effectiveness of oral penicillin except in the most refractory infections, such as subacute bacterial endocarditis. Furthermore, many clinicians are of the impression that, "there is less sensitivity to penicillin when it is given by mouth . . . than by the hypodermic method."[1]



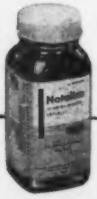
Vitamin and Mineral Potencies

Nutrient	3 capsules supply
Vitamin A	6000 units
Vitamin D	600 units
Ascorbic acid	100 mg.
Thiamine hydrochloride	3 mg.
Riboflavin	4.5 mg.
Niacinamide	30 mg.
Pyridoxine hydrochloride	0.5 mg.
Calcium pantothenate	3 mg.
Folic acid	1 mg.
Vitamin B_{12} (crystalline)	1 mcg.
Ferrous sulfate (succinated) 25.5 mg. per capsule, to supply: Iron	22 mg.
Purified veal bone ash to supply:	
Calcium	375 mg.
Phosphorus	187.5 mg.

Natalins also contains traces of copper, zinc, manganese, magnesium and fluorine.

All vitamins are in well tolerated (hypoallergenic) form.

Supplied in bottles of 100



NATALINS

the new small *prenatal capsule*

A nation-wide panel of practicing physicians revealed large sized capsules to be the greatest deterrent to patients' regular use of nutrient supplements during pregnancy.

Small and easy to swallow, NATALINS assures patient acceptance. This advantage, combined with small dosage, makes continued use more certain.

Formulated in accordance with the recommendation of this nation-wide panel of physicians, only three NATALINS daily provide generous vitamin and mineral supplementation in pregnancy.

NATALINS

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If you've been looking for better results in Lipotropic Therapy...

Stuart Lipotaine

Contains Betaine in addition to choline, liver and B_{12}—greater effectiveness. • Excellent taste and tolerance allows massive dosage when needed, assures complete patient cooperation.

Each TABLESPOONFUL contains:	
Betaine* . . (3000 mg.). .	3 Gm.
Choline*	210 mg.
Liver Fraction 1 N.F. . . .	210 mg.
Vitamin B_{12} (USP Crystalline)	12 mcg.

Each CAPSULE contains:	
Betaine*	333 mg.
Choline*	35 mg.
Desiccated Liver N.F. . . .	35 mg.
Vitamin B_{12} (USP Crystalline)	2 mcg.

*Active material

THE STUART COMPANY Stuart PASADENA 1, CALIFORNIA

If you've been looking for better results in Obesity Control...

Stuart Amvicel

One small capsule contains:

5 mg. dextro amphetamine sulphate, inhibits appetite, and produces a feeling of well being.

¼ gr. phenobarbital, offsets nervous stimulation.

200 mg. methylcellulose, supplies needed bulk.

9 vitamins** } supply protective amounts
8 minerals** } of nutritional factors

**Vitamins: A, 1700 USP units; D, 170 USP units; C, 25 mg.; B_1, 1 mg.; B_2, 1 mg.; Niacin Amide, 10 mg.; B_6, 0.15 mg.; B_{12}, 1 mcg.; Calcium Pantothenate, 1.5 mg. Minerals: Calcium, 40 mg.; Phosphorus, 30 mg.; Iron, 3 mg.; Copper, 0.25 mg.; Iodine, 0.05 mg.; Cobalt, 0.167 mg.; Manganese, 0.33 mg.; Zinc, 0.1 mg.*

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Stuart

Editorial

Craftsman's Pay

● "Those doctors—why, they're making a mint! Even family doctors are netting close to $15,000 a year."

Most of us get a mite irritated when we hear people talk like that. We think of the years of training. We think of the responsibility and the strain. In the light of these factors, medical incomes seldom strike us as being disproportionately high.

Most lay people take no such broad view. Nor can they really be expected to, since they lack our frame of reference. Medical training and medical responsibility are unfamiliar quantities to them.

But there's one quantity they can appreciate, and that's *time spent on the job*. Are doctors' incomes exorbitant when matched against the extra hours they work?

Though the concept of overtime work at overtime pay is familiar to Americans in general, it's seldom applied to a profession like medicine. Just to see what happens, let's apply it here. Let's compute the typical doctor's hourly base pay, assuming he gets time-and-a-half for overtime, double-time on Sundays:

According to our latest survey, the family doctor works an average of sixty-two hours a week. Twenty-two of these hours must be counted as overtime; perhaps five of these hours represent Sunday work. For pay purposes, therefore, he'd be credited with about seventy-five hours a week, or 3,750 hours a year.

Also according to our latest survey, the average family doctor nets $14,098 annually. Divide this figure by his hourly credits for the year (3,750) and you get the equivalent of hourly base pay. It turns out to be $3.76 an hour.

Now, the interesting thing about this figure is its strong resemblance to current base pay for skilled union labor. Many bricklayers, for example, get $3.25 an hour nowadays. And if other workers earn less, and if medical specialists earn more, isn't this explainable in terms of *degree* of specialized skill?

Don't misunderstand us: We're not saying that union and medical working conditions are anywhere near alike. We *are* saying that the skilled laborer and the typical doctor get roughly comparable hourly returns, assuming all overtime work is done at overtime pay.

Skilled craftsmanship, after all, deserves a skilled craftsman's pay. It may be news to our critics, but that's just about what most doctors are getting. —H. S. BAKETEL, M.D.

Beware of 'Simple' Tax Errors

Even a minor mistake may be an invitation to the T-man—and major trouble

● To err is human—but to forgive and forget is hardly in the nature of the Bureau of Internal Revenue. You can take the word of a California M.D. for this.

In his income tax return of two years ago, the doctor listed $2,000 in unpaid patient bills as "bad debts," then deducted the sum from his taxable income. Logic may have been on his side—but the Tax Code wasn't. Result: He had to spend valuable hours explaining the error.

That's not all. The T-man's curiosity was now aroused; so the physician had to face the ordeal of a minute check of his current and past returns. And, in the end, he had to pay taxes on the $2,000, plus interest at 6 per cent.

Of course, there was no question of jail, a fine, or a penalty. The error was an honest one, stemming from a misreading of the Treasury's rules. But careful checking could have avoided it—and could have avoided, too, a lot of extra worry and work.

You may know that the Treasury permits bad-debt deductions only when the uncollected money was actually a loan or was previously declared as income. So you wouldn't have pulled *this* boner. But are you aware of some of the other tax errors that doctors commonly make?

Here are the likeliest ones:

Deducting the costs of post-graduate medical training. A woman doctor in Boston spent $700 on a course in obstetrics. In her view, it was a necessary professional expense, so she deducted it. The revenue man didn't question the need for the outlay; but under the Tax Code, post-graduate training isn't deductible. So she, too, became host to a sharp-eyed revenue agent.

Taking full deductions for expenses that are only partly professional. For example, some doctors treat all the fuel, light, and telephone bills of a combination home-office as professional expenses. But whenever they do, the tax men are apt to come a-calling.

As the Treasury sees it, only part of such costs is attributable to medical practice. The rest is just the

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By John C. Post and Peter S. Nagan

**Mr. Post is a professional management consultant in Washington, D.C. Mr. Nagan is* MEDICAL ECONOMICS' *Washington correspondent.*

ordinary personal expense of running a home. So a physician must distinguish between these private (non-deductible) expenses and the professional (deductible) ones.

Similarly, the physician must allocate the costs of operating a dual-purpose automobile. But don't try to stretch the professional allocation too far. One M.D. in Florida deducted the cost of operating his wife's car; he maintained it, he said, for stand-by use in emergencies. Now his returns are being audited, too.

Or take entertainment costs. When they're connected with your practice—like, say, a dinner for colleagues who refer patients—a deduction is generally in order. But when you've simply had the boys in for poker, you'd better not call the party a professional expense—unless you're prepared to prove you gained new patients as a direct result.

Which Kind of Gain?

Making no distinction between long- and short-term capital gains. This is one of the commonest errors that doctors make in filling out their returns.

A long-term gain (profit from the sale of an asset held longer than six months) is taxed at only half the rate of ordinary income. When the asset has been held for six months or less the gain is considered short-term, and is taxed at the full rate (assuming in both cases that there are no offsetting losses).

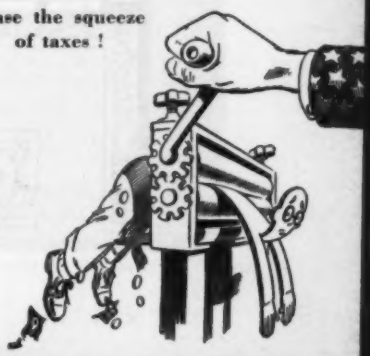
But to some doctors, the term "capital gain" is apparently synonymous with the lower rate. They make out their returns accordingly—and are rewarded with visits from the tax men.

Failure to understand the rules on capital gains can be costly to the taxpayer even when the bureau doesn't notice the error. For one thing, both long- and short-term capital losses are deductible in full (assuming there are no offsetting capital gains, and subject to a deduction limit of $1,000 per year). For another, there's the so-called "alternative" method of computing capital gains taxes—which can result in substantial savings if used at the right time.

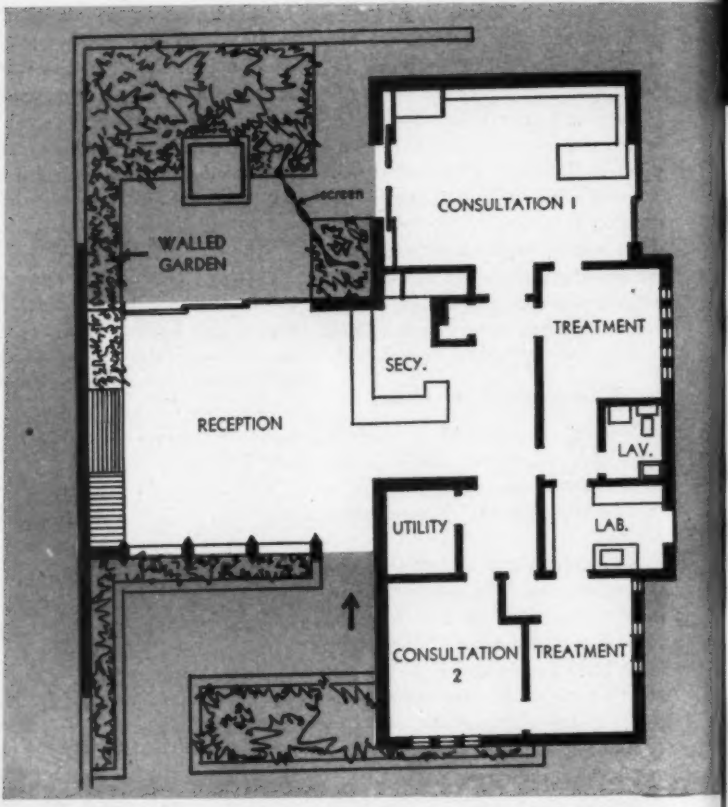
Got an Annuity?

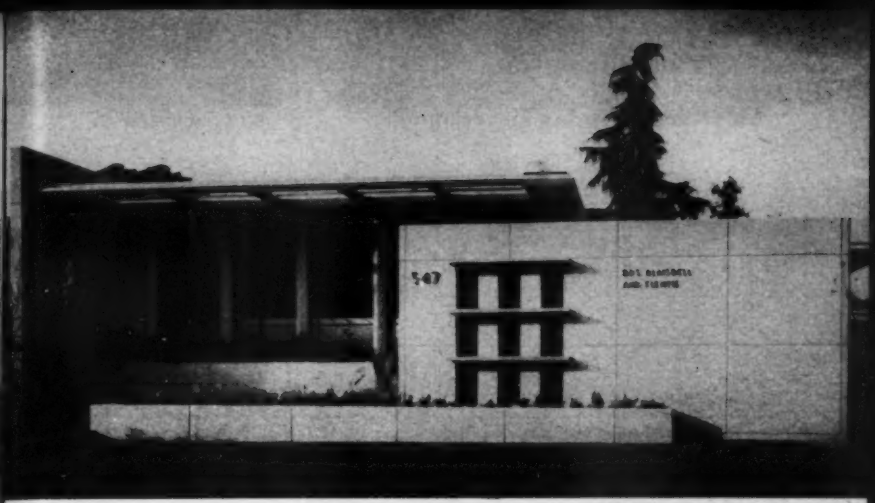
Failure to declare annuity income. Doctors who unhesitatingly report such familiar kinds of income as fees and dividends sometimes completely ignore income from annuities—usually on the theory that it's non-taxable. But this is only partly true.

The Tax Code [MORE ON 199]



An office to relax in . . .





SMITH AND WILLIAMS, ARCHITECTS

• Like many another medical man, Dr. Paul C. Blaisdell of Pasadena, Calif., wanted an office that would be pleasant and relaxing—one that would actually put patients at ease, instead of reminding them of a hospital, a commercial office, or a crowded railroad depot. The pictures on these pages show how he achieved his goal.

By Roger Menges

From the outside, you see a modern but not unusual two-man medical building, made of French gray concrete. But once inside, you sense the difference between this and many another office: It's designed to appeal to patients as well as doctors.

[MORE→

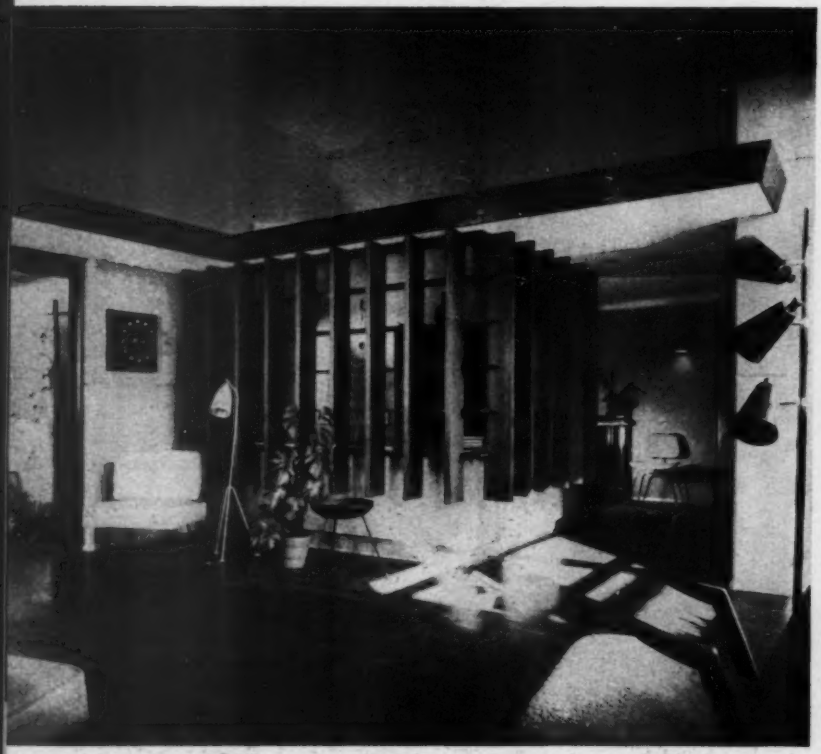
An Office to Relax In *(Cont.)*

Walled garden, off the reception room, provides extra waiting space as well as a restful view. Notice how the architect created the effect of one continuous room: Garden walls and floor are of the same colors and materials as the inside walls and floor; vine-covered trellis and lowered ceiling extend from inside to outside; sliding glass doors separate the two areas.

When the weather is too cool for patients to sit in the garden, they can enjoy the fireplace at the opposite end of the reception room. Floor of chocolate-colored concrete is good-looking, yet represents one of the cheapest possible constructions.

[MORE→

An Office to Relax In *(Cont.)*

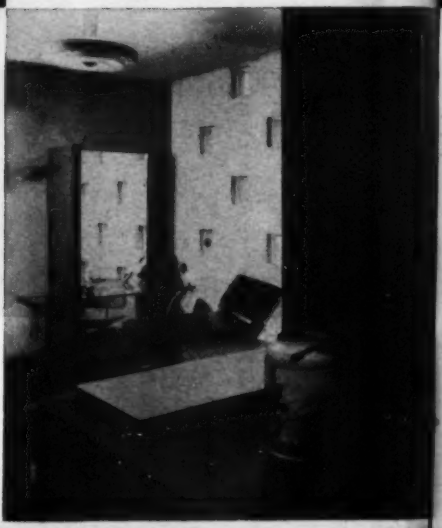


Secretary's work space is part of—yet seems apart from—the reception room. It's set off on two sides by a trellis effect that manages to keep the commercial flavor from intruding into the waiting area. For more privacy, the secretary can close sliding frosted-glass panels above her desk.

[MORE→

An Office to Relax In *(Cont.)*

Tile wall between consultation room and treatment room stops about two feet short of ceiling. Above that is a glass panel. Result: a sense of increased space, yet no loss of privacy.



To minimize the clinical appearance of the treatment room, instruments and supplies are stored in closed cabinets. Glass bricks let in enough daylight for routine examinations.

Medical books, diplomas, and such are kept out of sight in Dr. Blaisdell's consultation room. He feels they're more likely to depress than to impress patients. To avoid a businesslike atmosphere, he decided against a conventional desk. This one is built in, and part of its surface is slanted, like a school desk, for easier writing. The room opens on the walled garden.

END

Partnership Practice:

The Division of Income

• Whenever two physicians think about teaming up, they collide almost at once with the jackpot question: What are the best ways to divide partnership income?

There's no *one* best way, of course. While most of the two-man partnerships we've worked with have agreed on the same ultimate goal—a 50-50 division of net earnings—they've moved toward this goal in more than a dozen different ways. And each way has been considered "best" by the doctors concerned.

Take, for example, the division of income at the start. We've seen some partners begin with an 80-20 division; we've seen others start at 50-50; we've seen still others start at every major ratio in between. Who's to say which is best?

Or take the partners' timetable for arriving at income equality. Some men actually start on a 50-50 basis, as noted above; others reach this point after five years or ten; a few never reach it at all—and by design. Who's to say which is best?

Or take the "minimum" clauses that may supplement the percentage schedule. Some partners provide minimum guarantees for the junior—for example, $8,000 a year. A few provide minimum guarantees for the senior—for example, $15,000 a year. A very few provide minimum drawings for both. Who's to say which is best?

Well, as you might guess, the individual doctors are the ones to say.

How should they compare income-wise? It depends on how they actually *do* compare in age, train-

By Henry C. Black and Allison E. Skaggs

**This article is the third of a series. The first installment (November issue) dealt with the pros and cons of a partnership. The second (December issue) described how to get started. Later installments will cover the written agreement and dissolution provisions. The authors gained their experience in such matters through twenty years of operating Professional Management of Battle Creek.*

Most partners divide earnings on a shifting percentage basis, working toward 50-50. Some add minimum guarantees for junior or senior. These case histories show how income-sharing plans can be cut to the M.D.'s measure

ing, energy, experience, professional standing, earning potential, and size of existing practice. These are things that most partners-to-be must measure for themselves.

Their Aims Differ

Their income-sharing plan also depends on what each doctor wants. And since junior and senior generally want quite different things, each party is well advised to anticipate the other's point of view. Thus:

The younger physician wants a respectable income at the start—more than he'd get as a salaried assistant. He also wants progressive increases in his percentage share—preferably, 5 per cent more of the partnership's net earnings each year, at least until a 50-50 division is approached.

The older physician wants an undiminished income at the start; he'd prefer that taking on a partner didn't mean taking a loss. He also wants a *stabilized* income, with his decreasing percentage share compensated by the partnership's increasing volume. And he may expect to draw around 50 per cent of the partnership's net earnings even after he's stopped doing 50 per cent of the work.

These are reasonable expectations. But there are also unreasonable ones—as in the case of a few young doctors who "want to start where the old man left off."

Young physicians of this type tend to overvalue their own training. They tend to undervalue the work that has gone into building the senior's practice. As a result, they have inflated ideas on the starting percentage due them.

In one Michigan instance, when partnership negotiations stalled because of unrealistic demands by the junior, we urged him to go into practice for himself. Eventually, he did. Two years later, he conceded cheerfully to us that he *still* wasn't worth the percentage he'd originally thought he was worth.

Not Many Misers

Actually, the senior often proves more generous than the junior anticipates. When an Illinois surgeon

decided to take on a younger colleague, we suggested an initial income division of 65-35. "What are you trying to do?" the senior snorted. "Give my practice away?"

He finally accepted a 70-30 division. Then, as soon as he found that they worked well as a team, he hiked the junior to 35 per cent, ahead of schedule. Later, he bumped him to 40 per cent—still in advance of their written agreement.

Sometimes the senior is *too* generous with such boosts. Two internists in Wisconsin, for example, started on a 65-35 basis. Pleased with the junior's work, the senior raised him to full income equality within eighteen months.

But the older man wasn't the type who could slow down. He soon discovered that the younger doctor couldn't maintain his pace, and thus wasn't pulling his share. All sorts of tensions arose between them, and the partnership eventually broke up.

How to Plan Raises

If experience proves anything, it is this: Once the controlling partner starts raising the other's percentage share ahead of schedule, the latter comes to expect it. He's then likely to resent it when ahead-of-schedule boosts *don't* materialize. Most successful partners agree on a fair income schedule in the first place, rather than seek to make it fair through unscheduled hikes later on.

How far ahead should the income division be scheduled? Three to five years is often long enough. After all, no one can tell exactly how fast the junior M.D. will develop. No one can tell to what extent the senior may have to slow down. These uncertainties make a long-term schedule unnecessarily binding.

Once income equality is reached, of course, it can be extended indefinitely. But up to the 50-50 point, most partners prefer to schedule their percentages just a few years ahead, "and thereafter as mutually agreed."

Now, let's really get down to cases. What percentage divisions do physicians actually start with—and why? How fast do they change them? How far do they go?

Real-Life Examples

The partnerships described below are, in some cases, composites of several using the same income schedule. In other cases, the identifying details have been disguised. But real-life partnerships known to us are currently using these income-sharing plans:

Case A: Over a period of thirty years, a West Coast doctor had built up a large family practice. Then a heart condition forced him to slow down. He took on a young man fresh from military service as his salaried assistant. Eighteen months later, when the senior was 59 and the junior 28, they decided to form a partnership.

The senior had the experience, the reputation, the existing practice. On all counts except energy, the junior rated far [MORE ON 168]

Introducing

THE TWENTIETH CENTURY PHYSICIAN

By Helen Milius

● What contributions has modern science made toward easing the doctor's burden?

The telephone that rings day and night? The Cadillac that people make cracks about? The television set he doesn't have time to watch?

These are not unmitigated blessings. For with them have come new responsibilities and exasperating demands:

Patients used to revere the doctor for warding off untimely death. Now they demand a medical guaranty to health and happiness, with X-ray plates thrown in.

Since it's no easy job to deliver a daily millennium, why not some new accessories to simplify and embellish the physician's life? Why not, say, a watch with invisible hands, to allow him some time with his family? Or a bag with built-in boiling water for precipitous deliveries? Or a hole in the head, through which internes could watch his technique at the operating table?

Some pioneer research of this sort has been blueprinted by Boris Artzybasheff, universally known as a painter of covers and inside features for Time, Life, Fortune, and other periodicals; as a designer of stage sets; and as an illustrator of choice editions of current books.

His fellow-feeling for medical men stems from his own appearance (*see cut*): He believes he *looks* like a doctor ("people often mistake me for one and solicit medical advice"). So on the next two pages he sympathetically conjures up some new comforts and conveniences he thinks today's physician merits.

[Reprints of the Artzybasheff drawing, on 8" x 11" heavy gloss stock, suitable for framing, are available at 25 cents each. Tape a quarter to a card bearing your name and address and mail it in an envelope to Art Editor, MEDICAL ECONOMICS, *Rutherford, N.J.]*

THE TWENTIETH CENTURY PHYSICIAN

WITH REFINEMENTS BY ARTZYBASHEFF

legible bills.

Doctors Should Pay for Medical Care!

Professional courtesy is a noble tradition, but it's outmoded, says this M.D.

● One rainy night last summer, while my family and I were at our country home, my little boy developed a fever. As a neurologist, I'm a bit rusty on pediatrics. So I toyed with the idea of phoning our pediatrician and asking him to make the forty-mile trip over rain-sodden roads.

But the call would have disrupted his evening office hours. I decided, therefore, not to impose on him. In short, since I couldn't pay for his time, I preferred to gamble that my son's fever wasn't significant. Yet if I'd been a layman, I'd have called him without hesitation—and paid him adequately.

Luckily, I'd done no wrong. The boy was as chipper as ever in a few hours. But what if he hadn't been? What if the fever *had* been significant?

That started me thinking—and swapping experiences with colleagues. And I found that many doctors agree that it's about time to terminate the irritating ethic that restricts a physician from charging a fee for services to another doctor or his family.

Rooted in noble tradition, this custom was easy to carry out in the more primitive days of medical practice. But it's hopelessly unsuited to modern conditions.

Let's face it: Although the busy practitioner willingly gives free services to his colleague, he must mark down the time spent as a total loss. And the physician-patient may hesitate to call a doctor as often as he needs one, because he's a *beggar* rather than a *buyer* of these services.

A successful gastroenterologist can sell his time any morning for the price of a G.I. series. To schedule a physician-patient for that time is to take the fee right out of pocket.

I know a physician who suffered from rectal bleeding for two years before he consulted a proctologist. He was well aware that he needed a G.I. series plus a sigmoidoscopy. But he hated to take up a colleague's time without being permitted to pay for it. So he temporized with suppositories, rather than get a free ride—as he put it—on a busy practitioner's merry-go-round.

But it's not only the doctor who suffers. The pleasure *and pains* of

By Charles Miller, M.D.

professional courtesy are also visited on his family. Here's a real-life story that was told me not long ago:

The wife of a physician suffered from pains in the legs. She should have had X-rays, blood chemistries, oscillometry, electrical tests, and a thorough physical and neurologic examination. But her husband didn't want to put any of his medical brethren to all that trouble, so he gave her some anodynes. They

worked fine—until it became obvious that she had carcinoma of the spine.

Tough on Families

Our unwillingness to "bother" other physicians may indeed have tragic consequences. Is the answer simply that we ought to learn to be less hesitant?

I don't think so. I don't think we *could* help hesitating, under the circumstances. Consider the problem realistically:

The physician gives his colleague a top priority, of course. But behind this priority is an unspoken pressure to hurry him out of the office—to make way for a paying patient. There's nothing conscious about this. But with present appointment schedules so crowded, and with living costs so high, the doctor can't be blamed for not wanting to devote too many hours to non-paying professional activities.

Take the average specialist, for instance. Most specialists today are as busy as they want to be. Any additional free patient means either an extra load on an overburdened schedule or a direct financial loss through the crowding-out of a paying patient.

Gifts Don't Help

Will the loss be covered if the doctor-patient presents his colleague with a gift? Of course not.

In the first place, this is appropriate only for a major procedure like a surgical operation or an extended treatment. It's scarcely practical to offer a gift for every home or office visit.

In the second place, the donor may be so eager not to seem ungrateful that he'll spend *more* for the gift than he would have for a fee. He can't even claim the cost of the gift as a medical expense in his income tax return. And the gift is quite likely to be something the doctor neither needs nor wants. Everyone loses, therefore, except the gift-store.

Analysts Set Pace

The psychoanalysts have shown that it *is* possible to charge brother-physicians. They usually expect the doctor-patient to pay for each visit—and on perfectly realistic grounds. After all, the analyst sells his time at so much an hour; he has a limited number of hours and a long waiting list.

To give the M.D.-patient those hours gratis would be throwing money away. Besides, the analysts have a theory that treatment offered as a gift may be psychologically less effective.

These arguments, it seems to me, are valid at least in part for the profession as a whole. And don't forget that most physicians can *afford* to pay for medical care. They should, therefore, be *ashamed* to ask for it gratis!

Good medical care is admittedly expensive. No one who can pay the price should expect to get it free.

END

Your Economic Weather Vane

A report on the
Seventh MEDICAL ECONOMICS Survey

The facts in the following pages stem from the replies of about 5,000 practicing physicians to a questionnaire sent them by this magazine in April, 1952. These doctors constitute a representative cross-section of the profession; the information they supplied covers many phases of the economics of private medical practice in the U.S. In previous installments of survey data, we discussed such topics as the "average" physician, incomes, and general practice. This month we take up doctors' expenses. In the months ahead, we'll analyze such matters as collections, working hours, patient load, and assistants. For a detailed account of how the Seventh MEDICAL ECONOMICS Survey was conducted, see page 96.

Your Economic Weather Vane
(Cont.)

Physicians' Expenses

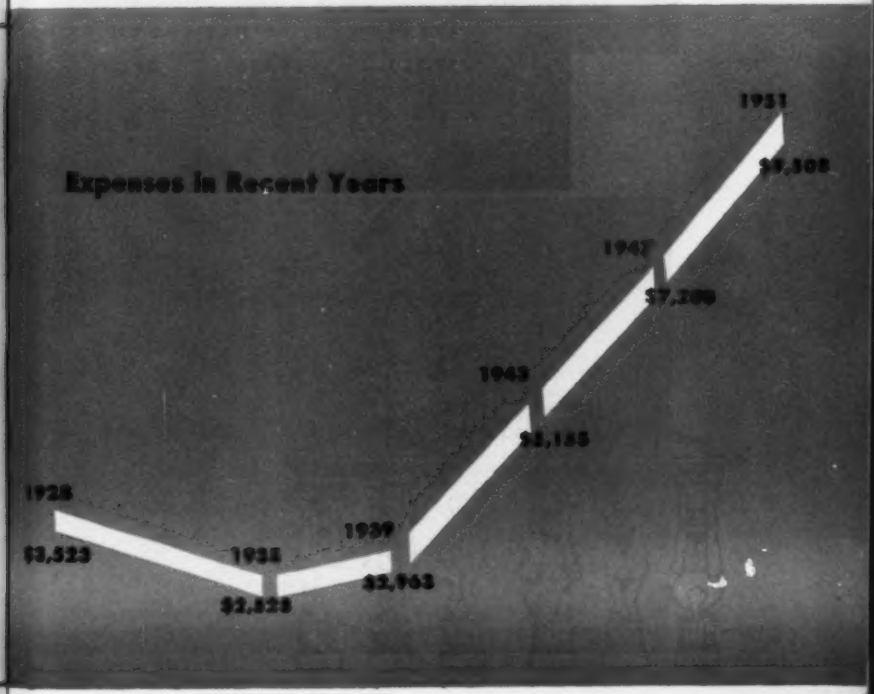
Average professional expenses amount to $9,508

Expenses equal about 39 per cent of gross income

(Average gross income: $24,644)

Unless otherwise noted, the figures cited in this article are 1951 averages based on the *non-salaried* practice of independent physicians (those who derive more than half their net income from fees for service).

Despite varying economic conditions through the years, operating expenses have consistently claimed about two-fifths of the average physician's gross income. Expenses-as-per-cent-of-gross amounted to 38 per cent in 1928; 41 per cent in 1935; 40 per cent in 1939; 36 per cent in 1943; 40 per cent in 1947; and 39 per cent in 1951.



Your Economic Weather Vane

(Expenses—*Cont.*)

Expenses at Various Gross-Income Levels

	Expenses	Expenses as % of Gross
$ 5,000	$ 2,585	53%
10,000	4,304	43
15,000	6,389	43
20,000	7,601	38
25,000	9,616	38
30,000	11,475	38

Expenses by Years in Practice

	Expenses	Expenses as % of Gross
Under 10	$ 8,652	39%
10-19	11,362	41
20-29	9,356	38
30 and over	7,671	41

Expenses by Community Size

	Expenses	Expenses as % of Gross
Under 5,000	$10,251	44%
5,000-49,999	10,223	39
50,000-499,999	9,727	37
500,000-999,999	8,762	37
1,000,000 and over	7,875	39

Your Economic Weather Vane

(Expenses—*Cont.*)

Physicians' Major Expenses

Office salaries	Drugs and supplies
$2,689	$1,944

Rise in Major Expenses, 1947-1951

	1947 Expenses	1951 Expenses	Percentage Rise
Office salaries	$2,357	$2,689	14%
Drugs and supplies	1,532	1,966	28
Office rent	1,026	1,149	12
Auto upkeep	739	882	19
Instruments/equipment	584	661	13
Miscellaneous	962	2,161	125
Total expenses	$7,200	$9,508	24%

Office rent	Automobile upkeep	Instruments, equipment	Miscellaneous
$1,149	$882	$661	$2,161

Total expenses: $9,508

Your Economic Weather Vane

(Expenses—*Cont.*)

Major Expenses by Community Size

	Under 5,000	5,000-49,999	50,000-499,999	500,000-999,999	1,000,000 and over
Office salaries	$2,307	$3,073	$2,984	$2,540	$2,091
Drugs and supplies	3,144	2,276	1,760	1,243	1,131
Office rent	570	943	1,420	1,476	1,375
Auto upkeep	914	846	777	855	904
Instruments/equipment	702	741	768	475	450
Miscellaneous	2,614	2,344	2,018	2,173	1,924
Total expenses	$10,251	$10,223	$9,727	$8,762	$7,875

Major Expenses at Selected Gross-Income Levels

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
Office salaries	$ 388	$ 792	$1,367	$2,024	$2,649	$3,047
Drugs and supplies	387	846	1,491	1,595	2,020	2,391
Office rent	598	798	997	1,027	1,202	1,302
Auto upkeep	404	714	766	819	874	1,003
Instruments/equipment	210	294	446	489	794	808
Miscellaneous	698	860	1,322	1,647	2,067	2,924
Total expenses	$2,585	$4,304	$6,389	$7,601	$9,616	$11,475

Your Economic Weather Vane

(Expenses—*Cont.*)

Office Salaries According to Patients Seen Daily

Under 10	$1,274
10-19	1,879
20-29	2,964
30-39	3,592
40 and over	6,403
All patient loads	2,489

Office Rent in The Various Regions

New England	$ 840
Middle East	995
Southeast	1,005
Southwest	1,235
Central	1,085
Northwest	1,275
Far West	1,880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ARIZ.
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ME.
VT.
N.H.
MASS.
R.I.
CONN.
N. J.
DEL.
MD.
Far West
Northwest
Southwest
Central
Middle East
Southeast
New England

Your Economic Weather Vane
(Cont.)

About the Seventh MEDICAL ECONOMICS Survey:

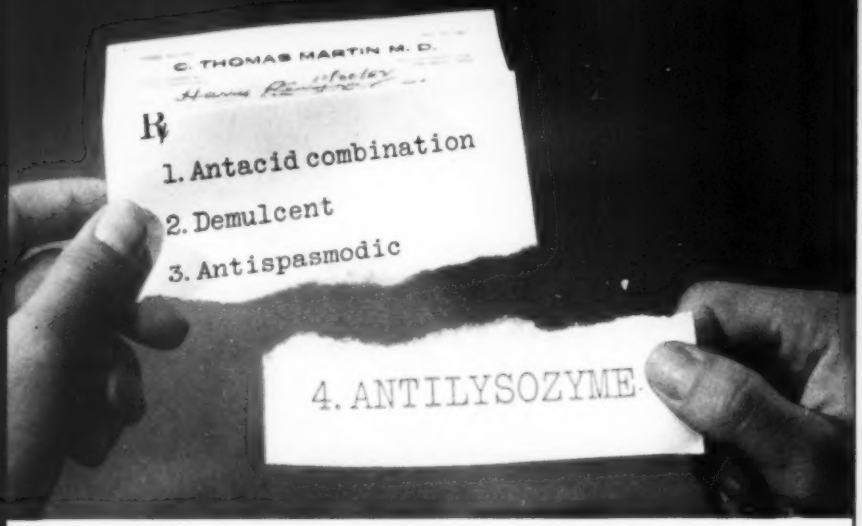
• It was in 1929—a few months before the stock market crashed—that MEDICAL ECONOMICS published the results of its first survey of the economic status of U.S. physicians. More recent surveys, made every few years since then, have examined the doctor's practice through the lean days of the depression, the exhausting days of World War II, and the unsettled days of the post-war period.

The Seventh MEDICAL ECONOMICS Survey is the most comprehensive yet attempted. Like earlier ones, it was planned and prepared for publication by the editorial staff of this magazine, with the technical aid of consultants in research and statistics. The detailed statistical work was done by Columbia University's Bureau of Applied Social Research.

Who participated in the study? Copies of the questionnaire were sent by direct mail to a cross-section totaling about one-third of the country's active, private physicians. It was also published in the April, 1952 issue of the magazine—which circulates, of course, to almost all private practitioners. Excluded from the survey group were doctors over 65, internes, residents, and medical men in full-time government service.

About 8,000 questionnaires were returned by the time statistical work was begun. Since this was a considerably larger sample than necessary for stable results, a free hand was used in discarding incomplete or inaccurate returns.

Other questionnaires were eliminated in order to make sure that the sample constituted a valid cross-section of doctors the country over. Actually, the unadjusted sample closely approximated the known distri-



Isn't this too often the missing fourth

in peptic ulcer therapy?

KOLANTYL INCLUDES THE IMPORTANT 4th FACTOR

1. **A SUPERIOR ANTACID COMBINATION** (magnesium oxide and aluminum hydroxide, also a specific antipeptic).
2. **A SUPERIOR DEMULCENT** (methylcellulose, a synthetic mucin).
3. **A SUPERIOR ANTISPASMODIC** (BENTYL Hydrochloride) which provides direct smooth muscle and parasympathetic depressant qualities without "belladonna backfire."
4. **INACTIVATION OF LYSOZYME**—Laboratory research and clinical studies[1,2] indicate that lysozyme plays an important role as one of the etiologic agents of peptic ulcer. By inhibiting or inactivating lysozyme with sodium lauryl sulfate, KOLANTYL includes the important 4th factor toward more complete control of peptic ulcer.

KOLANTYL

DOSAGE: 2 Kolantyl tablets or 2 to 4 teaspoonfuls of Kolantyl Gel every 3 hours as needed for relief.

1. Hufford, A. R., Rev. of Gastroenterology, 18:588, 1951
2. Miller, B. N., J. So. Carolina M. A., 48:1, 1952

TRADE-MARKS "KOLANTYL," "BENTYL"

bution of physicians by three key variables: community size, geographic area, and years in practice. But it included a somewhat too great proportion of full specialists in relation to partial specialists and general practitioners. So, by means of a system of random discarding that preserved the close correlation with the other three variables, a number of questionnaires from full specialists were removed.

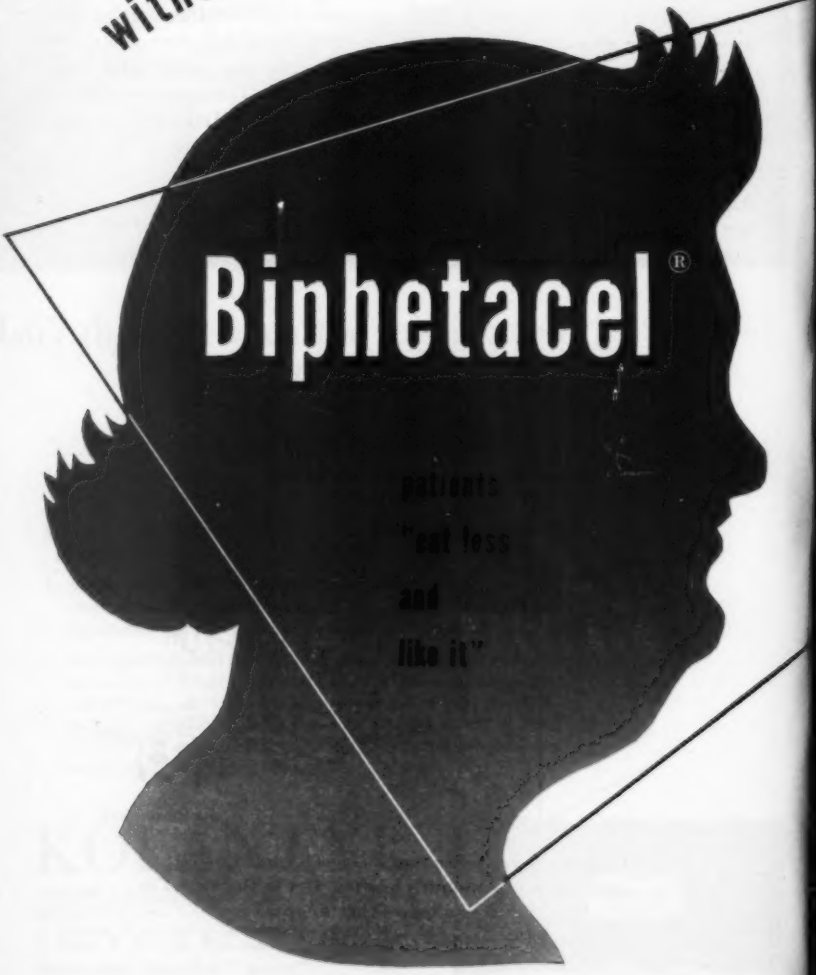
The sample thus arrived at contained 5,009 questionnaires. Of these, 4,268 were returns from independent doctors (i.e., those who derive more than half their net income from non-salaried practice). Except where otherwise qualified, the survey breakdowns are based on the replies of these independent practitioners alone.

Results of the survey are being presented, several topics a month, in MEDICAL ECONOMICS. Breakdowns are made by such factors as years in practice, city size, geographic area, and specialty. The survey results are also being published in booklet form. END

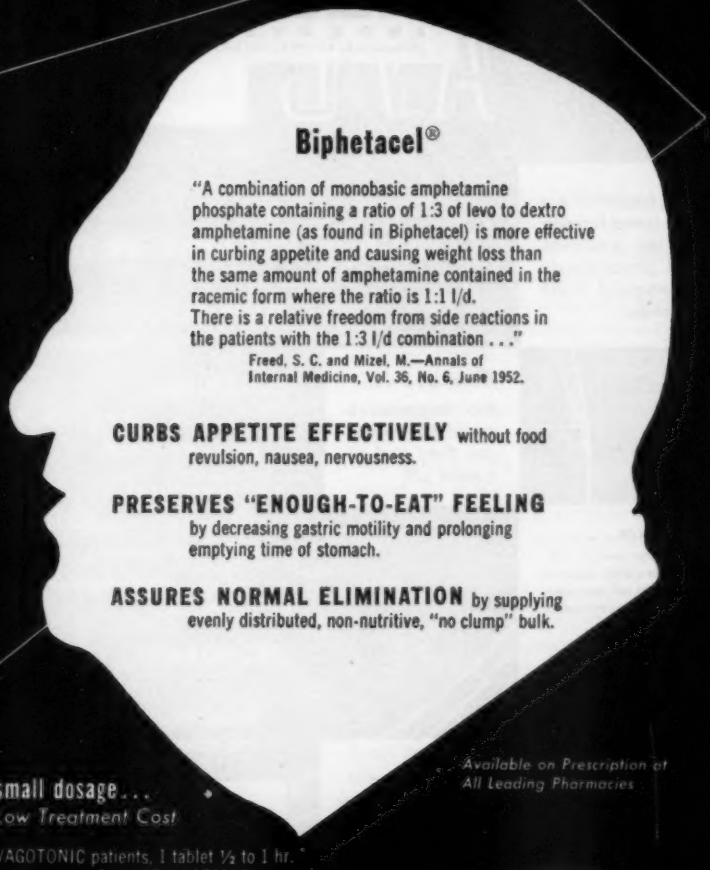
This is a condensation of a more detailed discussion of the purposes and methods of the Seventh MEDICAL ECONOMICS Survey. For the full text, see the October, 1952 issue.

"For the type of operation I've performed on you, my usual fee is one month's income. But in this case I'm going to leave it up to you."

for positive appetite control
without side effects...



Exclusive 1:3 L/D ratio



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"A combination of monobasic amphetamine phosphate containing a ratio of 1:3 of levo to dextro amphetamine (as found in Biphetacel) is more effective in curbing appetite and causing weight loss than the same amount of amphetamine contained in the racemic form where the ratio is 1:1 l/d. There is a relative freedom from side reactions in the patients with the 1:3 l/d combination . . ."

Freed, S. C. and Mizel, M.—Annals of Internal Medicine, Vol. 36, No. 6, June 1952.

CURBS APPETITE EFFECTIVELY without food revulsion, nausea, nervousness.

PRESERVES "ENOUGH-TO-EAT" FEELING by decreasing gastric motility and prolonging emptying time of stomach.

ASSURES NORMAL ELIMINATION by supplying evenly distributed, non-nutritive, "no clump" bulk.

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Low Treatment Cost

VAGOTONIC patients, 1 tablet ½ to 1 hr. before meals. SYMPATHICOTONIC patients, ½ tablet ½ to 1 hr. before meals.

Each scored tablet contains Racemic Amphetamine Phosphate Monobasic 5 mg., Dextro Amphetamine Phosphate Monobasic 5 mg., Metropine® (methyl atropine nitrate, Strasenburgh) 1 mg., Sodium Carboxymethylcellulose, 200 mg.

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For Vaginal Tract Infections

AVC

IMPROVED
(Allantoide VAGINAL CREAM)

In
TRICHOMONIASIS
MONILIASIS
MIXED INFECTIONS

AVC Improved is a time tested formula for the treatment and prophylaxis of vaginal tract infections.

QUICK RELIEF · EASILY APPLIED · NON-IRRITATING

Because . . .
AVC Improved re-establishes the normal flora and the normal pH.

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AVC Improved is indicated in a wide range of infections of the exocervix, vagina and vulva:

- ***Trichomoniasis***
- ***Moniliasis***
- ***Specific and non-specific bacterial infections***
- ***Mixed infections.***

Because . . .
AVC Improved suppresses secondary invaders . . . an important therapeutic goal.

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Especially monilia.

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Especially certain gram-positive and gram-negative cocci and bacilli.

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Voluntary Plans Can Do the Job

Onetime backer of compulsory health insurance indicates a major change of heart

● This nation is on the threshold of a new era in health service expansion. During the past decade, we have increased our consumer outlay for health by almost 300 per cent. The increased use of tax funds for such purposes has been still greater.

Even after allowances for ballooning costs and a growing population, we have, in the last ten years, allocated a higher percentage of personal and national resources to health than ever before in our history.

This has made possible greater use of health services and higher standards of care. But we are faced, none the less, with an economic problem that is not unlike the "lag" we find in other fields of our expanding national life.

The problem can be stated simply: We must find effective ways to close the gap between the level of health service we now give the majority of our citizens and the level of health service we *know how* to give.

We should not be sidetracked into carefully documented studies on the extent of the gap. There *is* a gap; and most of us are against it.

We must bear in mind that as the general educational level rises in this country, people become more articulate and insistent in their demand for the best health service attainable. The standard of living of the American people is expected to increase by 3 to 5 per cent a year. These are important considerations in the "tooling up" necessary for the health job ahead.

Expanding our health services to fill the gap that now exists must be done in a way consistent with our tradition of individual responsibility. It must also be done in accordance with our pattern of using Government as an instrument for achieving things that we cannot do alone or as members of voluntary groups.

With all our progress, we are still not allocating enough money to

---

***By Harry Becker** associate director of the Commission on Financing of Hospital Care. In 1946 he testified in support of the Wagner-Murray-Dingell bill.*

**This article approximates portions of Mr. Becker's testimony before the President's Commission on the Health Needs of the Nation. The author is*

*in musculoskeletal pain

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or as required for individual patient.
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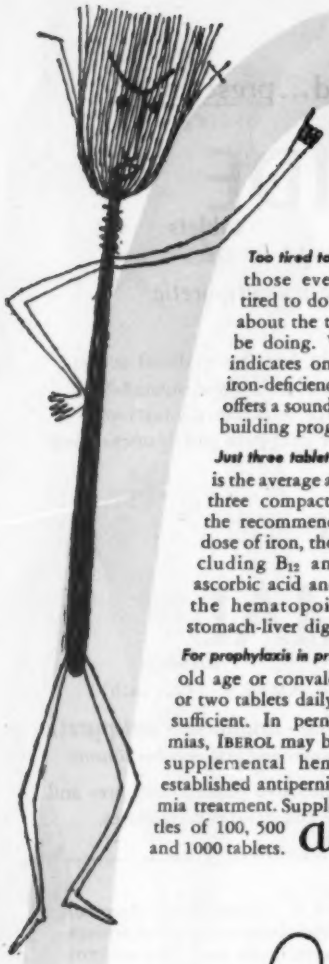

bullied by a broom

Too tired to tackle

those every-day chores, too tired to do anything but worry about the things she ought to be doing. When examination indicates one of the common iron-deficiency anemias, IBEROL offers a sound, all-in-one blood-building program.

Just three tablets a day

is the average adult dose. These three compact tablets supply the recommended therapeutic dose of iron, the B vitamins including B_{12} and folic acid, ascorbic acid and, to conserve the hematopoietic factors, stomach-liver digest.

For prophylaxis in pregnancy,

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Ferrous Sulfate, U.S.P.....1.05 Gm.
(representing 210 mg. elemental iron, the active ingredient for the increase of hemoglobin in the treatment of iron-deficiency anemia)

Plus these nutritional constituents:

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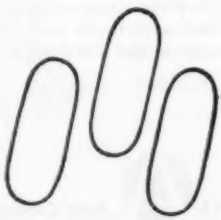
Riboflavin	6 mg. (3 x MDR*)
Nicotinamide	30 mg. (2 x RDA†)
Ascorbic Acid	150 mg. (5 x MDR*)
Pyridoxine Hydrochloride	3 mg.
Pantothenic Acid	6 mg.
Vitamin B_{12}	30 mcg.
Folic Acid	3.6 mg.
Stomach-Liver Digest	1.5 Gm.

*MDR—Minimum Daily Requirement
†RDA—Recommended Daily Dietary Allowance



Three Iberol Tablets, the average daily therapeutic dose for adults, supply:

1-65

health services. Evidence of this is the national shortage of hospital beds, the need to modernize most hospital plants, and the shortage of professional and technical personnel. Another indication of under-financing is the retarded development of preventive, diagnostic, and rehabilitation services.

What proportion of the nation's income *should* be allocated to health? This is not a decision for the technician, but for the consumer. Whatever the answer, one fact stands out:

The major *source* of health income today is: voluntary prepayment.

Public acceptance of voluntary prepayment is now an established fact. In hardly a decade, more than half the population of our country has sought such protection. Moreover, the number of persons so protected is growing at a rate of about 1 per cent a month. So we have had ample experience with prepayment to know that it is an effective economic tool.

If voluntary prepayment plans are to achieve their full potential, they must serve as the basic means of budgeting consumer expenditures for health. Such plans will not have met the ultimate test until they provide the following:

Prepayment Goals

¶ Comprehensive benefits—including most of the cost of such expensive illnesses as cancer and heart disease, and protection for the chronically ill;

¶ Coverage of all employed persons and their dependents, plus such other population groups as have personal resources to meet the cost of prepayment; [MORE→

"I understand, of course . . . But we've all had to make promises we couldn't keep."

¶ Preventive and diagnostic services;

¶ Consumer representation at the policy-making level.

Growth of the voluntary prepayment plans would be speeded greatly by official government recognition of such plans. One step toward such recognition would be for Government to allow its employes to participate on a payroll-deduction basis in voluntary plans that meet specific standards.

Government might also explore the feasibility of bringing certain groups of public beneficiaries into the voluntary prepayment plans; for medical and hospital care of people who cannot pay for it themselves is now badly under-financed. Welfare agencies have not increased their payments for health care at a rate commensurate with today's increased cost of services. The result is that the cost of care given indigents is a serious economic drag on those agencies that provide it.

We cannot close the existing gap in health services until we accept a pattern of financing. Such a pattern would embrace voluntary prepayment that is self-financed by the employed and Government-financed for the medically indigent.

Let us remember, in our search for better ways to organize and distribute health services, that we face danger along any path of mere expediency. Sound health planning demands that we think in terms of ten to twenty years from now.

END

The Legal Mind

● Several years ago, a young doctor of my acquaintance sat as a key witness in a widely-publicized homicide trial. When he took the stand, the opposing counsel, well aided by medical experts, put him through a grueling cross-examination. The attorney then propounded a long and involved hypothetical question.

The doctor listened with steadily rising temper, then turned to the judge.

"Your Honor," he said, "I'm just a country practitioner and this is the first time I've testified in a homicide case. Any of the authorities at that table"—he nodded toward the counsel's corner—"undoubtedly can tell you much better than I how the deceased *might* have died, *could* have died, or even *should* have died.

"I can only tell you how he actually *did* die. I can do that because I was there. Do I get any chance to talk about that?"

He did.

—M. W. WARREN

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Diarrhea in Oral Antibiotic Therapy

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The troublesome diarrhea, so frequently encountered as an undesirable side action in oral antibiotic therapy, is effectively prevented by Arobon. The dehydration and the debilitating influence of frequent bowel movements are avoided, thus aiding in more prompt recovery.

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White Plains, New York

Your Tax Questions Answered

Separate or joint? · dependents' earnings · taxable gifts · political gifts · interest on taxes · non-practice losses · sale of old goods · state taxes

Separate or Joint

Should my wife and I file separate returns or a joint one?

Your tax is likely to be lower if you file a joint return. Separate returns would mean a saving for you only under very special circumstances—for instance, if you both had separate capital gains or losses. A joint return might, in that event, deny you the favorable treatment accorded long-term gains.

Suppose my wife and I file separate returns and then, later, wish we hadn't. Can we change to a joint return at that stage?

You can switch from separate returns to a joint one any time up to three years after the due date of the original return. But you may *not* do the opposite and switch from a joint return to separate returns.

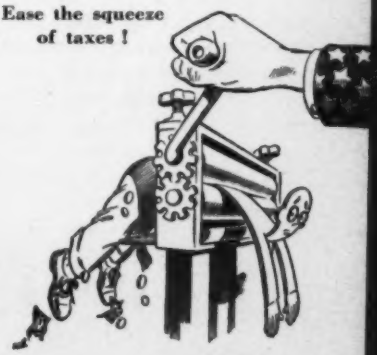
Dependents' Earnings

My 15-year-old son earned $300 last summer as a copy boy on our town paper. Am I still entitled to his $600 exemption? And if I am, must I add his earnings to my own income?

This is once when you can have your cake *and* eat it. As long as a dependent's earnings remain under $600, this income need not be reported; and the taxpayer may still claim exemption.

Taxable Gifts

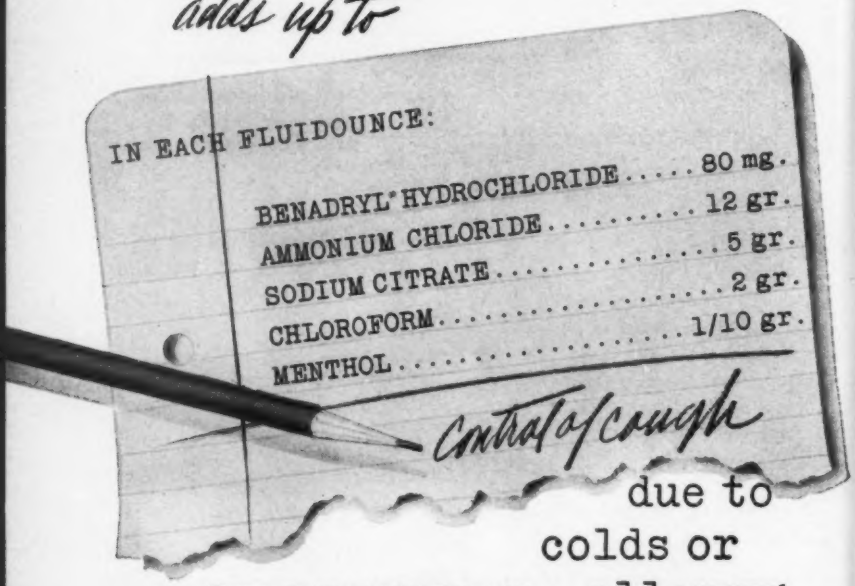
In appreciation of my obstetrical services, a colleague's wife gave me a handsome instrument bag. Do I



By John C. Post and Peter S. Nagan

Benylin® Expectorant

adds up to



due to colds or allergy'

Because BENYLIN EXPECTORANT combines BENADRYL Hydrochloride – highly effective decongestant and antispasmodic – with established non-narcotic remedial agents, it provides rapid relief of cough. BENYLIN EXPECTORANT promotes patients' comfort by liquefying mucous secretions, relaxing the bronchial musculature, soothing irritated mucosae and relieving nasal stuffiness, sneezing and lacrimation. Patients of all ages like its mildly tart, raspberry flavor.

DOSAGE: One or two teaspoonfuls every two to three hours. Children, one-half to one teaspoonful every three hours. Supplied in 16-ounce and 1-gallon bottles.

MEDICAMENTA VERA

Parke, Davis & Company

have to pay an income tax on it? If so, how do I do it?

Technically, the bag is income and should be so reported at its market value—that is, at its estimated cost. But, actually, tax agents would probably consider the bag a non-taxable gift, since it is clearly a small present and not an expensive substitute for a fee.

Political Gifts

I contributed to the campaign of my congressman, who has an active interest in legislation affecting medicine. Can I deduct the contribution as a professional expense?

No. Contributions to political parties, candidates, or organizations concerned primarily with electing candidates are not deductible. But a contribution to an essentially non-political organization—like the A.M.A.—is deductible, even though the organization may use some of the money to help influence legislation, directly or indirectly.

Interest on Taxes

I made an error in my tax return last year and had to pay a deficiency, plus $175 interest. Is this interest tax-deductible?

Yes. Almost all interest is deductible, even interest on tax deficiencies.

Non-Practice Losses

An apartment house I own lost $2,000 last year. Can I deduct this sum from my taxable income?

Yes, you can deduct business losses, even though they're not connected with your medical practice. This holds not only for losses on real estate but also for losses on a farm run as an investment or on a store or manufacturing establishment in which you have a financial interest. Such losses should be listed separately on your tax return.

Sale of Old Goods

When redoing my office last spring, I sold some furniture that I had fully depreciated. Do I have to pay tax on the proceeds of the sale?

Yes. You must treat the proceeds as a long-term capital gain. Had you used the old furniture as down payment on the new, you would have then technically realized no gain—and have been liable for no taxes.

State Taxes

Is it true that all state taxes are deductible from the Federal income tax, and that all U.S. taxes are not?

No. The line isn't drawn that neatly. You may, for instance, deduct the Federal Social Security taxes you pay as an employer; and you may deduct Federal excise taxes whenever the item taxed is itself deductible. (This last would apply, for instance, to any society dues or telephone service taxed by the U.S. Government.) But you may not deduct Federal income, gift, and inheritance taxes or ordinary Federal excise taxes on non-deductible items.

On the other hand, though state and local income, real estate, and most excise taxes are deductible, local inheritance taxes *aren't.* END

RECOMMENDED READING ON

BUTAZOLIDIN

(brand of phenylbutazone)

for

ARTHRITIS

and allied disorders

new... synthetic...

non-hormonal...

orally effective

The remarkable clinical effectiveness of BUTAZOLIDIN in producing striking relief of pain, coupled with functional improvement, is the subject of recent authoritative reports.

Journal of the American Medical Association 149:*729 (June 21) 1952.*

Kuzell, W. C., and others: Phenylbutazone (Butazolidin®) in Rheumatoid Arthritis and Gout.

Gout: "... 25 of the 48 gouty patients experienced a complete remission in 48 hours or less."

Journal of the American Medical Association 150:*1087 (Nov. 15) 1952.*

Steinbrocker, O., and others: Phenylbutazone Therapy of Arthritis and Other Painful Musculoskeletal Disorders.

Osteoarthritis: In 63 per cent "... there was improvement of functional capacity ranging from slight to complete, with striking enhancement of coordinated movements. ..."

Journal of the American Medical Association 150:*1084 (Nov. 15) 1952.*

Stephens, C. A. L., Jr., and others: Benefits and Toxicity of Phenylbutazone (Butazolidin®) in Rheumatoid Arthritis.

Spondylitis: "Of the 32 patients ... 25 patients (80%) showed 3 to 4 plus subjective improvement."

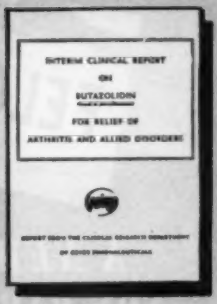
Bulletin on Rheumatic Diseases 3:*23, 1952.*

Kuzell, W. C.: Phenylbutazone (Butazolidin®).

Rheumatoid arthritis: "Its use is followed by substantial relief of symptoms in about 80 per cent of patients with rheumatoid arthritis."

from the clinical research department of Geigy Pharmaceuticals

AN INTERIM REPORT on BUTAZOLIDIN



First of a series, the Interim Clinical Report on BUTAZOLIDIN summarizes and analyzes the literature on this important new agent. Mailed recently to the medical profession, additional copies are available on request.

BUTAZOLIDIN is a totally new and outstandingly effective agent in the therapy of virtually all forms of arthritis. In most indications it produces relief of pain in approximately 75 per cent of cases and measurable functional improvement in 50 per cent.

In relation to its high degree of effectiveness BUTAZOLIDIN is of relatively low toxicity. However, to obtain optimal results with minimal risk of side reactions physicians are urged to read the mentioned reports in their entirety.

Physicians are also invited to write our Medical Department for the brochure, "Essential Clinical Data on BUTAZOLIDIN," *and other informative literature.*

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FELO'RAL
FELORAL CAPSULES are packaged in moisture-proof strips for their protection; easily carried in purse or pocket.
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Samples? Of course . . . on your request.
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Originators of CHLORAL HYDRATE in Soft Gelatin Capsules

Chiropractors Plan V.A. Coup

And they may get American Legion support in their campaign for recognition

• The nation's chiropractors are about to launch their biggest campaign yet for recognition. This year will probably see their supreme effort to force the Veterans Administration to include chiropractic treatment in its medical program. And this effort may succeed, unless doctors everywhere take a hand in the fray.

How do the chiropractors expect to win their point in 1953? Their immediate objective is to gain the active support of the country's largest and most vociferous veterans' organization, the American Legion. So they're already gathering the fireworks they hope to touch off at the Legion's 1953 convention in St. Louis.

Their primary weapon will be a barrage of perhaps 10,000 affidavits from veterans who claim they've had to consult chiropractors—and to pay their *own* bills—because veterans' hospitals and out-patient clinics couldn't help them. The chiropractors apparently reason that this strategy should convince the Legion that their treatment works. As a result, they believe, the Legion will gladly lobby for the addition of chiropractic to the V.A. program.

Organized medicine has more than held its own against similar maneuvers in the past. But it's apprehensive over this scheme. Says Thomas A. Hendricks, secretary of the A.M.A. Council on Medical Service:

"Unless the doctors of the nation take an active interest in their local Legion posts and do the homework in their state departments—particularly in such key states as New York, Illinois, Pennsylvania, and Texas—the battle to lower medical standards for veterans' care is sure to be fought all over again at this year's convention. Many Legionnaires are becoming tired of this perennial wrangling . . . the only way to end it is for individual doctors who are veterans to get to work."

The trouble is, of course, that medicine hasn't up to now been heavily represented in the American Legion. Only a small percentage of M.D.-veterans are members; and few of these are really active.

With chiropractors, however, it's a different story. An unusually high percentage of the veterans among them are Legionnaires. They com-

By Morris Weintrob, M.D.

NON-NARCOTIC . . NON-BARBITURATE . . . NON-ACID

Strascogesic acts directly in three ways, maintaining its effect for 3 to 4 hours.

. . . Provides rapid and effective analgesia

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Metropine® (methyl atropine nitrate) 0.5 mg.

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Administered as Easily as Insulin:
Subcutaneously or intramuscularly with a minimum of discomfort.

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One to two doses per week in many cases.

Rapid Response, Prolonged Effect:
Combines the two-fold advantage of sustained action over prolonged periods of time with the quick response of lyophilized ACTHAR.

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Recent significant reduction in price, and reduced frequency of injections, have advanced economy of ACTH treatment.

ACTH dramatically relieved severe pain and restored motion within 24 to 48 hours from onset of symptoms in 3 of a group of 6 patients with acute calcific rotator-cuff tendinitis of the shoulder.[1] The other three obtained relief and regained motion within a few days when treated with ACTH.

Equally successful treatment with ACTH was given to a number of patients with acute subacromial bursitis.[2] In one instance an area of calcification adjacent to the deltoid muscle cleared up completely within less than 4 weeks, as demonstrated roentgenographically. Pain disappeared and function was restored.

In no instance did pain recur upon withdrawal of ACTH. The short period of treatment precludes overdosage effects.

HP*ACTHAR *Gel*, the new repository ACTH, provides complete convenience and ease of administration in short-term treatment of these acute conditions.

1. Quigley, T. B., and Renold, A. E.: New England J. Med. 246: 1012, 1952.

2. Steinberg, C. L., and Roodenburg, A. L.: J.A.M.A. 149: 1458, 1952.

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PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

prise the entire membership of at least one post. And they make every effort to work their way up in Legion politics. A few years ago, an Oklahoma chiropractor attained the high honor of being elected to the National Executive Committee, the Legion's governing body.

The Background

It's no wonder, then, that the chiropractors have had an impact on the most powerful of veterans' organizations. The force of that impact becomes evident when we look at the records of the past three Legion conventions.

Take, for example, the 1950 convention in Los Angeles. At that time, the California delegation submitted a resolution recommending the establishment of chiropractic treatment for sick and disabled veterans under the V.A. program. The spiritual godfather of this resolution was the National Chiropractic Association.

The resolution was approved in committee by a one-vote margin. When it came to the floor, it brought with it a minority report saying, in effect, that the American Legion should not become a battleground for opposing factions of the healing arts: "Let them take their legislative lobbies to Congress."

But the resolution was passed, and the Legion went on record as urging the Veterans Administration to include chiropractic treatment. The V.A. rejected the advice. Still, the mere passage of the resolution was a thumping victory for the chiropractors. It revealed the extent of their influence with the veterans' lobby.

Strong Backing

The question came up again at the Legion's 1951 convention in Miami, Fla. And though, this time, the resolution never got as far as the floor, it once more had strong support in committee.

The last try the chiropractors made was at the Legion's 1952 convention in New York last August. Eight almost identical resolutions were submitted to the Rehabilitation Committee. All sought to require the Veterans Administration to permit veterans to elect Government-financed treatment by chiropractors.

But after a thorough study, the committee recommended the rejection of all eight resolutions. And when one of them came up for a floor vote, it lost by a margin of 1,344 to 1,729.

States for Chiropractors

This was a clear-cut victory for physicians. But the vote also proved that the chiropractors are firmly entrenched in many areas of the country. Delegations that voted solidly for the chiropractic resolution included Alabama, Alaska, Florida, Hawaii, Illinois, Mississippi, Montana, New York, Oregon, Pennsylvania, Puerto Rico, Rhode Island, and Texas. And there was considerable support for it in the California, Delaware, Indiana, Louisiana, Min-

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orally effective ANTIBIOTIC

ERYTHROCIN

TRADE MARK

(ERYTHROMYCIN, ABBOTT)

IN SPECIALLY COATED TABLETS ***of low toxicity***

ESPECIALLY EFFECTIVE AGAINST GRAM-POSITIVE ORGANISMS

FAVORABLE REPORTS from a number of investigators[1-4] indicate that there is a new and valuable addition to the antibiotic field.

The new antibiotic is called ERYTHROCIN (pronounced ē-rĭth′-rō-sĭn), Abbott's trade mark for erythromycin. It is effective orally against a wide variety of organisms, particularly the gram-positive ones, and also against certain gram-negative organisms.

ERYTHROCIN is supplied in *Specially Coated* tablets to preserve it from the destructive effects of gastric secretion. This carefully formulated coating masks the drug's bitter taste and also permits rapid absorption from the upper intestinal tract. The special coating permits higher blood levels than uncoated tablets, particularly if the drug is administered with meals.

Clinical and laboratory reports indicate that ERYTHROCIN has low toxicity. No serious side actions have been reported at the recommended doses; only an occasional case of nausea, diarrhea or vomiting. A lower incidence of toxic reactions is to be expected because ERYTHROCIN does not decrease the intestinal population of *E. coli*. There may be, consequently, less tendency for markedly abnormal intestinal flora to occur.

ERYTHROCIN is generally indicated in infections produced by staphylococci, streptococci and pneumococci. In many respects its spectrum of activity is similar to penicillin. However, ERYTHROCIN has an important difference. It appears effective against gram-positive organisms which have developed resistance to penicillin or to the other antibiotics.

ERYTHROCIN is recommended for the treatment of infections such as pharyngitis, tonsillitis, scarlet fever, erysipelas, pneumococcal pneumonia, osteomyelitis, pyoderma and others produced by organisms susceptible to its action.

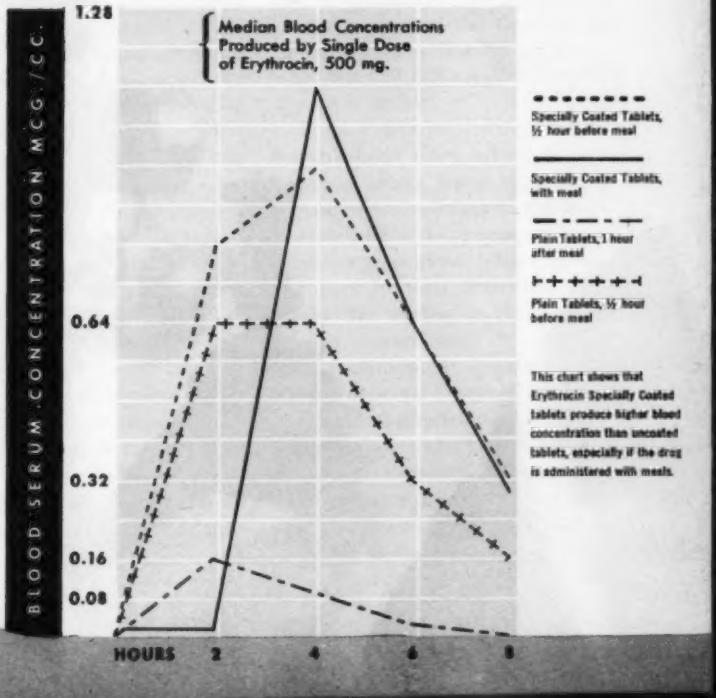
As with any new drug, the full potential of side effects may not be known until its use has become extensive. So if long or repeated administration of ERYTHROCIN is necessary, patients should be observed for possible signs of toxicity to all systems.

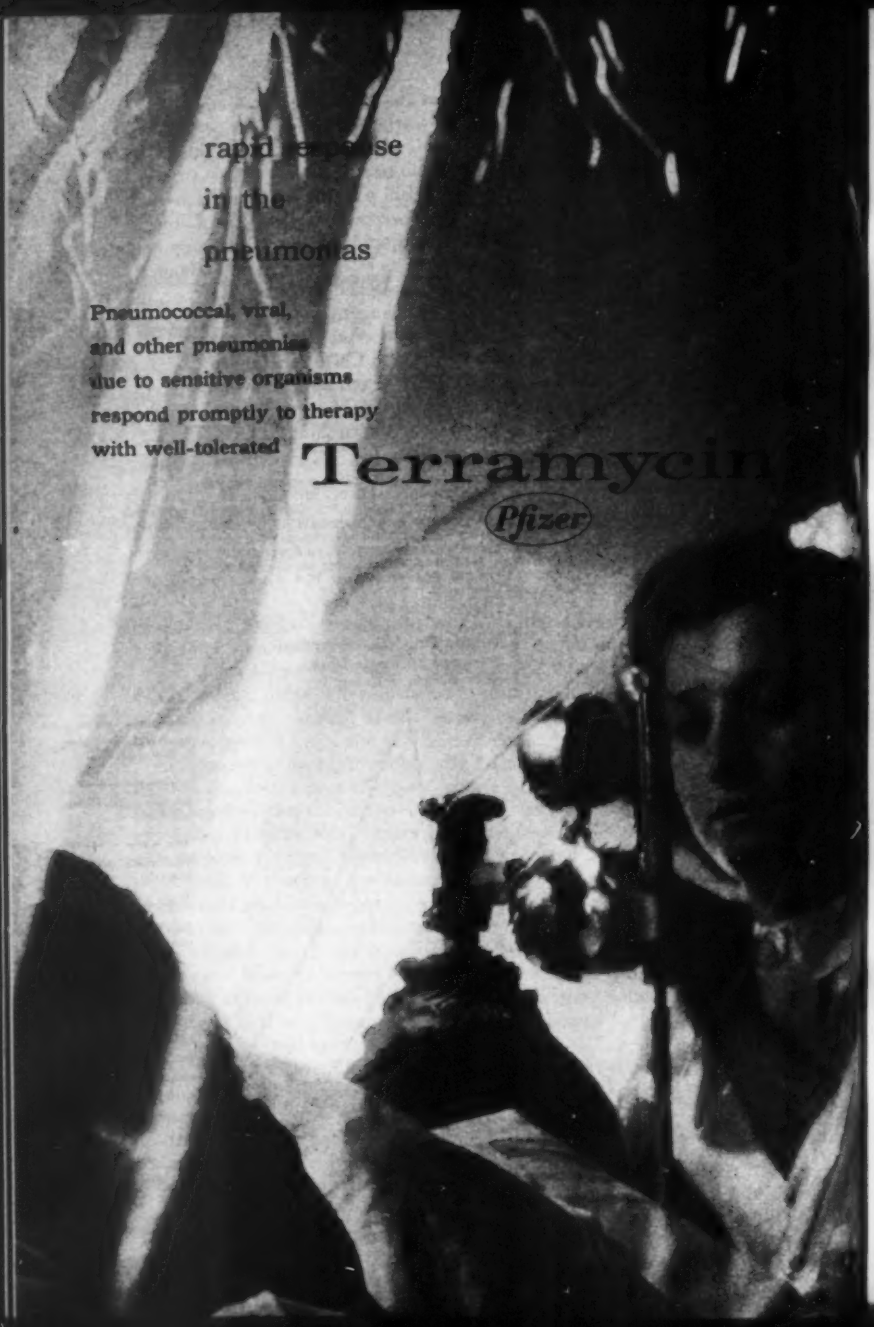
You will be kept informed of new developments. But meanwhile, in order that you may benefit from ERYTHROCIN in your practice, contact your Abbott representative, or write to Abbott Laboratories, North Chicago, Illinois, for literature. Dosage, clinical studies and indications are fully discussed. ERYTHROCIN, 0.1-Gm. Tablets, *Specially Coated*, are supplied in bottles of 25.

Abbott

1/Haight, Thomas H., and Finland, Maxwell (1952), Laboratory and Clinical Studies on Erythromycin, The New England J. Med., 247:227, August 14. 2/McGuire, J. M., Bunch, R. L., et al. (1952), "Ilotycin," A New Antibiotic, Antibiotics and Chemotherapy, 2:281, June. 3/Hellman, F. R., Herrell, W. E., Wellman, W. E., and Geraci, J. E. (1952), Some Laboratory and Clinical Observations on a New Antibiotic, Erythromycin (Ilotycin), Proc. Staff Meet. Mayo Clinic, 27:285, July 16. 4/Rammelkamp, C. H. (1942), A Method for Determining the Concentration of Penicillin in Body Fluids and Exudates, Proc. Soc. Exper. Biol. & Med., 51:95-97.

Higher Blood Concentrations Produced by Specially Coated Tablets

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in the
pneumonias
Pneumococcal, viral,
and other pneumonias
due to sensitive organisms
respond promptly to therapy
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nesota, Ohio, and Oklahoma delegations.

Although the 1953 convention is still months away, the chiropractors are already hard at work lining up fresh support for their position. One of their most ardent backers—a New York post-office employe active in Legion general service work—tipped off their plan of attack recently in a memorandum to like-minded Legionnaires. Some verbatim quotations:

"There are many states . . . where some real work can be done to prepare for St. Louis. [It] should start right now, through key men in various departments, and once again do not make contacts with bulletins, this should not be published, it should be done quietly.

"One of the most important things we need, in my humble opinion is a vigourous campaign to secure sworn affidavits from veterans now being adjusted by Chiropractors and which should state that they want this service through the veterans administration. Those affidavits loaned to me by [a delegate to the 1952 convention] indicated that one man in Louisville, Ky., had about 18 of them. And let me assure you that these were shown to some key men in the New York delegation and it registered heavily. It should be an easy task for us to go into the next convention with a stack of ten thousand sworn affidavits of veterans asking for Chiropractors . . .

"The Editor of the Stars and Stripes . . . is not only on our side, but is willing to give us a front page spread on the question . . .

"Although we took a licking [in 1952], I firmly believe that we made a lot of friends and with more work on the part of our steering committee plus all the help they can possibly get from the rest of the field, we should go into the St. Louis Convention with many more mandated states . . .

"We want ten thousand sworn affidavits. We want resolutions from more and more states . . . we need the help of every one we can get. So let's get busy."

What Can Doctors Do?

To help counter the chiropractors' attack, physicians are banking on the support of the Legion's top brass, which is heavily pro-medicine. But will this support convince the lower ranks?

Frankly worried because M.D.'s haven't been more active in local veterans' affairs, the A.M.A. is urging physician-veterans to get busy.

How? First, by joining the veterans' organizations. Then, by taking part in their activities. And, finally, by serving as delegates to Legion conventions.

The chiropractic question is, of course, only one of several problems that concern physicians and the veterans' organizations jointly. For that reason, the coming Legion convention will bear close watching. And the best way for medical men to watch it is to attend it—as active participants. END

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TRI-SULFANYL...still **safe**, most **effective**, most **economical** chemotherapy

single or mixture . . .

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maximum efficacy . . . because of rapid, prolonged high blood and tissue levels.

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unusual palatability . . . delightful flavor of syrup appeals to infants, children, women, all patients.

Each 5 cc. of Tri-Sulfanyl syrup (approx. one teaspoonful) or each tablet contains 7½ grains of sulfa compound:	
SULFADIAZINE	0.162 Gm.
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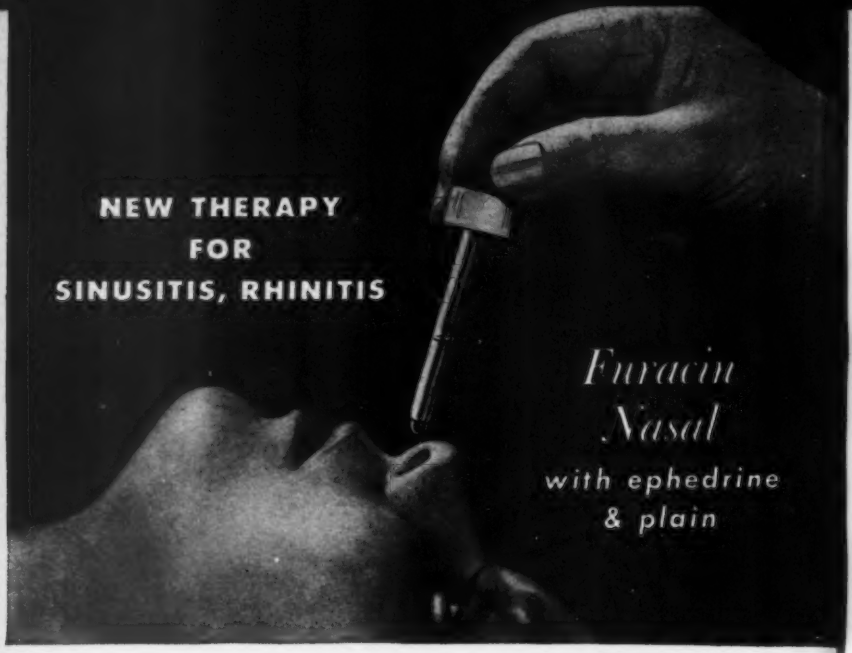

Excellent results are being obtained with Furacin Nasal in cases of acute and chronic sinusitis and rhinitis. It is being administered by dropper, atomizer, cannula or the displacement technic.

Even those notoriously refractory conditions: atrophic rhinitis and ozena* show marked benefits from Furacin therapy.

* Thornell, W. C.: Arch. Otolaryng. 52:96 (July) 1950.

REASONS FOR EFFECTIVENESS OF FURACIN . . .
A wide antibacterial spectrum, including many gram-negative and gram-positive organisms • Effectiveness in the presence of wound exudates • Lack of cytotoxicity: no interference with healing, phagocytosis or ciliary action • Water-miscible vehicles which dissolve in exudates • Low incidence of sensitization • Ability to minimize malodor of infected lesions • Stability.

Furacin Nasal plain contains Furacin® 0.02% brand of nitrofurazone N.N.R. in an isosmotic, aqueous vehicle.

Furacin Nasal with ephedrine contains, in addition, ephedrine • HCl 1%.

EATON Inc.
NORWICH, NEW YORK

Literature on request

Want a Part-Time Industrial Practice?

You may first have to show a near-by plant the wisdom of setting up a medical department. Here's how

• To the doctor who can spare a few hours a week from his regular private practice, part-time industrial work frequently offers a rewarding change of pace. The average part-time industrial physician makes out all right financially, too, $10 an hour being about the lowest rate of payment he's expected to accept.

Such a doctor has the added satisfaction of knowing that he's performing a truly valuable service; for all the available statistics, logic, and expert opinion indicate that a medical program can be a genuine asset to almost any industrial concern.

Where can you expect to find an industrial connection most easily? With any company, of course, that already has a medical department in operation. The problem is that there may be no ready-made openings within easy commuting distance of your office. And you probably don't want a part-time position that entails much traveling.

Well, then, why not try some small plants in your neighborhood that do *not* have medical departments? If you can convince the owner of one of them that he needs such a unit, you stand to be first in line for the assignment of running it.

You've probably had dealings with the officers of near-by companies over compensation cases. If so, you have a tailor-made opportunity to show them how a plant medical program would, among other things, cut down on accidents—thus reducing their compensation insurance costs.

Or you can approach some of the local industrial leaders you've met on the golf course, at civic-club meetings, or in your examining room. In any case, your main objective is to point out to the executive how an organized medical program will benefit *his* plant.

Arm yourself with the necessary facts and figures. Know your subject. Cite the astonishing extent to which accident frequency, absenteeism, labor turnover, occupational diseases, and compensation insurance premiums have been reduced in plants that have set up medical departments. Perhaps suggest that

By Wallace Croatman

you come to the plant an hour a day as a starter, to give management a chance to survey the results.

Good general evidence of the value of a medical program may be found in a study involving some 3,500 plants, made by the National Association of Manufacturers in 1951. The surveyed companies, representing every section of the U.S., constituted a wide range of sizes and types. They reported the following average savings from setting up medical departments:

¶ A 44 per cent drop in accident frequency;

¶ A 46 per cent drop in occupational diseases;

¶ A 29 per cent drop in labor turnover;

¶ A 39 per cent drop in absenteeism;

¶ A 30 per cent drop in compensation insurance premiums.

Behind the Statistics

At first glance, these figures may seem too good to be true. So the major part of your presentation may well consist of explaining *how* it's possible for a medical program to produce such results. Here are the points you'll want to get across:

Examinations. The keystone of any worth-while program is a provision for pre-employment and periodic physical examinations. Reasons:

(1) Such a set-up minimizes the hiring of persons for jobs they're not physically equipped to fill.

(2) It enables an employer to place handicapped workers where they're most suited.

The first point is obviously a big factor in avoiding accidents. The second is of special importance these days, when a tight labor market makes industry rely more and more on elderly and physically handicapped persons.

Doctor Boosts Output

Morale. Other things being equal, a company with a well-run medical department will recruit more and better workers than a plant that still lives by the first-aid-kit-on-the-wall tradition. It's all part of that mysterious morale factor to which industrial leaders are now paying such close attention.

Morale may seem to be a pretty intangible thing. Yet the effects of good morale are easily gauged in terms of production. As all but the most old-fashioned employer realizes, the quantity and quality of a worker's output depend largely on his attitude toward his employer, his job, and his working conditions.

If the employe feels that the company has his welfare at heart (as he's likely to in a plant with a good medical department), he's inclined to work a little harder than he otherwise would. The same inclination is there when he's doing a job he's suited to. It's there, too, when he knows he'll get adequate medical attention if he's hurt on the job.

Unions. Linked to morale is the increasing problem of labor-union agitation for on-the-job medical at-

A Positive Way to Overwhelm Bacterial Invaders

Occasions arise when there must be *no shred of doubt* that penicillin dosage is adequate. Here especially 'Duracillin F.A.' *One Million* is indicated. Penicillin—G, sodium, 250,000 units (for immediate effect), is combined with procaine penicillin—G, 750,000 units (for prolonged effect), for a total of *1,000,000 units in a single dose.* Susceptible organisms are exposed to intense and prolonged antibiotic action.

'Duracillin F.A.' *One Million* is supplied in one-dose and ten-dose waste-free* ampoules. Only 0.7 cc. of sterile aqueous diluent is added for each million-unit injection. The total volume of the ready-to-inject suspension is 1.25 cc. The dry penicillin salts are stable at ordinary temperatures until the diluent is added. Refrigeration is required only after mixing. Keep a supply on hand. Your local pharmacist will be glad to serve you. Call him today.

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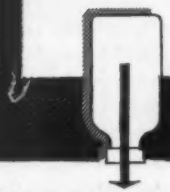


Lilly

*Fortified aqueous suspension in free-flowing silicone-lined ampoules

To avoid risk of undertreatment, use

AMPOULES

Duracillin F.A.

ONE MILLION

(Procaine Penicillin and Buffered Crystalline Penicillin, Lilly)

FOR AQUEOUS INJECTION

tention. Maybe the employer you're talking to has never encountered this problem. If so, that's all the more reason he should consider putting in a medical department now—before labor leaders start to press for a program of their own choosing.

Indoctrination. Before you present your case for industrial medicine to an employer, inform yourself about any health problems peculiar to *his* plant. Sometimes you can piece together useful data from your own practice.

For example, you may have noticed frequent outbreaks of respiratory infections among employes of the furniture factory in town. When you talk to the head of the plant, you'll want to stress how a medical department, by focusing attention on proper sanitary precautions, could help reduce the transmission of infections.

How Expensive?

Costs. Sooner or later, if an employer is at all taken by your arguments, he's going to ask for a realistic estimate of what a small-plant medical program costs. Obviously, you won't be able to answer him exactly; but you can assure him that a well-integrated program will add only slightly to his over-all budget. According to the N.A.M. study, the

"I could cure you all right; but after hearing about your financial worries, your in-laws, your back-breaking job, and your demanding wife, I ask you: What's the use?"

Only on your Rx . . .

When prescribing Ergoapiol (Smith) with Savin for your gynecologic patients, you have the assurance that it can be obtained only on a written prescription, since this is the only manner in which this ethical preparation can be legally dispensed by the pharmacist. The dispensing of this **uterine tonic**, time-tested ERGOAPIOL (Smith) WITH SAVIN —only on your prescription—serves the best interests of physician and patient.

INDICATIONS: Amenorrhea, Dysmenorrhea, Menorrhagia, Metrorrhagia, and to aid involution of the postpartum uterus.

GENERAL DOSAGE: One to two capsules, three to four times daily—as indications warrant.

In ethical packages of 20 capsules each, bearing no directions.

ERGOAPIOL (SMITH) WITH SAVIN

Literature Available to Physicians Only.

Ethical protective mark, M.H.S., visible only when capsule is cut in half at seam.

MARTIN H. SMITH COMPANY
150 Lafayette Street • New York 13, N. Y.

average small company (250 employes or less) that had a health-medical-safety program in 1951 spent about $45 per capita on it. That's less than an employer pays toward an average worker's annual Social Security premium.

How It Pays Off

What return can the employer expect on his investment? The Public Health Service (which cooperates with industrial medical programs in such ways as giving chest X-rays to employes) estimates that for every dollar an employer invests in a good program he stands to get back $1.50 in long-range dividends.

But the final proof of the pudding is in the eating; and the fact remains that the vast majority of plants that have medical departments are well satisfied with them. Of all the company executives questioned by the N.A.M., less than 1 per cent failed to consider their program a paying proposition.

Quite possibly your prospective employer won't be galvanized into action by such nation-wide figures alone. So locate a small plant in your own vicinity that has made its program pay off. Find out *how* it succeeded, then tell your prospect the story.

Chances are, a local example like this will impress him more than anything else—especially if the plant is engaged in the same, or a comparable, line of work. END

Unethical Advertising (Vintage 1908)

• "While it is perfectly proper to seek reputation by legitimate means, avoid all sensational scheming to obtain practice. Attempts to puff one's self, one's cases, or one's skill into celebrity by using odd-colored vehicles, oversized initials on carriage-panels, or peculiar-looking horses or ponies; or pretending to be overrun with business by driving unnecessarily fast, appearing and disappearing with a swish-sh-sh; or blowing a cloud of tobacco smoke and attempting to read as the carriage whirls along; or having one's self unnecessarily called out of church at the most solemn part of the service; or, worse still, affecting odd-style hats, long hair, and heavy canes; or showing everybody affected kindness—all [these things] generally fail in their object and are looked upon as either an unethical display of artifices or the efforts of a small mind to hide other deficiencies."

—Condensed from "The Physician Himself," by D. W. Cathell, M.D., Philadelphia, 1908.

Political Action, Medical Style

This city's health was menaced by public inertia, till the doctors fought—and won—a battle of ballots

● At this writing, Miami—that "polluted paradise," as local novelist Philip Wylie once called it—is still a winter playground built around an open cesspool. But after alternately deploring and overlooking their health hazard for fifty-eight years, Miamians have at last voted to quit dumping 40 million gallons of raw sewage daily into their front yard.

Thanks largely to Miami physicians, who recently went all-out to help put over a big bond issue, a modern sewage disposal system is soon to be built. The story of how local doctors fought and won their battle for community health is an interesting one. But, more important, it serves as an example of the influence medical men can wield when they lead a public health campaign.

Between Miami, on the mainland, and the lucrative pencil of sand that is Miami Beach, lies mile-wide Biscayne Bay. Into it flows the narrow Miami River; and into both, from seventy-four outlets, flows most of the sewage of the Miami area's half-million inhabitants. Not open to the cleansing action of tides, the bay has been a bathtub of bacteria.

Naturally, health authorities and the medical profession have long worried about this menace to public health. Two years ago, for example, the 700-member Dade County Medical Association publicly warned that Miami was courting disaster. But its protest against the antiquated method of sewage disposal got the society nowhere.

Yet the doctors had a watertight case. The Florida Board of Health had tested the water and found it "heavily contaminated." So the board condemned swimming and water skiing in the bay, forbade the use of raw shellfish caught there, and warned Miamians against eating improperly cooked fish from the area.

Finally, even the fish couldn't take it. One day early in 1952 a large school of them turned up their stomachs in the oxygen-depleted water and died. City crews dredged

---

By Margaret P. Thale

**The author was formerly associated with the Dade County Medical Association, Miami, Fla.*

PIONEERING

the first true Hematopoietic stimulant

RONCOVITE

Specific Bone Marrow Stimulation in Anemia

Medical research has recently proved that full therapeutic doses of cobalt exert a consistent and pronounced hematopoietic effect on bone marrow—a property which has not been demonstrated by any other compound.

Roncovite, the pioneer cobalt-iron preparation, has a remarkably rapid stimulating effect on the human blood producing mechanism. Because of this action, Roncovite opens an entirely new field in the therapy of human anemia.

The mechanism of the "cobalt effect" has been shown to differ completely from the "catalytic" effect of trace elements and from that of vitamin B_{12}.

HEMATOPOIETIC EFFECT OF COBALT

Effect on Erythrogenesis and Hemoglobin

Pharmacologically, it is now well established that cobalt administration causes a rapid and striking hematopoietic response. An initial increase in reticulocytes is promptly followed by pronounced increases in the red cell count and in hemoglobin. [1,2,6,7,17,18,19,20,25] The bone marrow undergoes progressive hyperplasia of all cellular elements[13] and shows increased numbers of erythrocyte precursors.[8,9]

In experimentally induced anemia, cobalt accelerates recovery from hemorrhage,[8] overcomes the hemopoietic depression due to inflammation[10] and is superior to iron, copper-iron, liver extract or vitamin B_{12} in preventing the anemia produced by hypophysectomy.[24]

See next page for clinical results

Clinical Results

Early reports on the use of cobalt in the treatment of human anemia have been extended and clarified by recent clinical investigations.

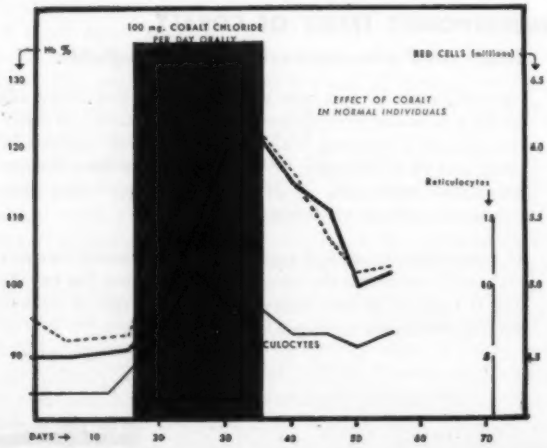
In anemic infants and children a definite pattern of response follows Roncovite therapy with increases in erythrocytes and hemoglobin levels. An average weekly gain of 250,000 erythrocytes and 0.6-0.7 Gm. of hemoglobin has been reported,[13,27] despite the fact that many of the children so treated had failed to respond to iron.

Striking results likewise have been reported in adult secondary anemia.[16,22,25]

As one investigator[13] summarizes:

—the anti-anemia effect of cobalt can be expected in anemias where the bone marrow is capable of regenerative action. In such cases the hematopoietic effect is even greater than in the normal individual and is proportional to the severity of the anemia.

Marked erythrocyte increases, often of 50% or more of the initial value, are noted. In addition, if adequate iron reserves are present, parallel increases in hemoglobin are characteristic.



. RONCOVITE

Roncovite (Cobalt and Iron) For Full Effect

The erythropoietic effect of cobalt does not depend on the presence of iron, since cobalt administration alone will cause erythrogenesis even in the presence of iron deficiency and may lead, in this way, to a hypochromia.[19] Since iron is necessary for hemoglobin synthesis, Roncovite provides ferrous sulfate to insure adequate iron reserves and thus permits hemoglobin increases to accompany erythrogenesis under the influence of cobalt.

Clinical Applications of Roncovite

Cobalt therapy has given excellent results in secondary anemia accompanying chronic inflammatory diseases, infections, tuberculosis, chronic hemorrhage, pregnancy, iron deficiency anemia, idiopathic hypochromic anemia, erythrogenic hypoplastic and hypochromic microcytic anemia.

Dosage

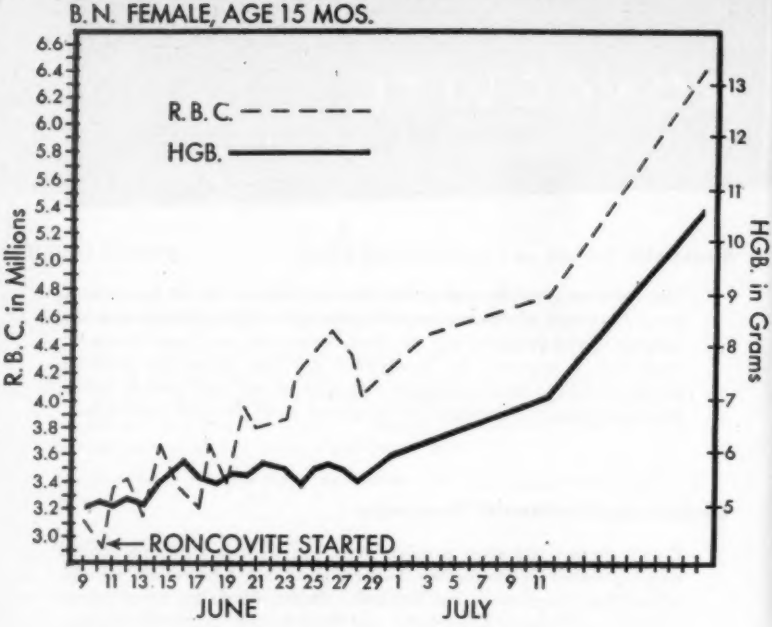
The recommended daily dose of 4 Roncovite Tablets provides 60 mg. cobalt chloride.

The recommended daily dose of 0.6 cc. of Roncovite Drops provides 40 mg. cobalt chloride.

Both preparations provide, in addition, the necessary iron to maintain adequate iron reserve.

Daily oral doses of 60 mg. of cobalt chloride in adults, or 40 mg. in children and infants, have been shown to be effective hematopoietic stimulants, and are well tolerated. These doses may be increased if desired. Gastrointestinal side-effects, as evidenced by anorexia or nausea, are rare at the recommended dosage levels. The appearance of such side effects at higher dosage levels are an indication for reduction of the dose.

How To Prescribe Roncovite (next page)



Preparations Available

RONCOVITE TABLETS

Each Enteric Coated, Red tablet contains:

Cobalt chloride.....15 mg.
(Cobalt as Co.....3.7 mg.)

Ferrous sulfate, exsiccated.....0.2 Gm.
(Iron as Fe.....60 mg.)

Average Adult Dosage: 1 tablet after each meal and at bedtime.

Supplied: bottles of 100 tablets.

RONCOVITE DROPS

Each 0.6 cc. contains:

Cobalt chloride.....40 mg.
(Cobalt.....9.9 mg.)

Ferrous sulfate.....75 mg.
(Iron.....15.1 mg.)

Average Dose: 0.6 cc. (10 minims) diluted with water, milk, fruit or vegetable juice once daily to infants and children.

Supplied: bottles of 15cc. with calibrated dropper.

Complete bibliography supplied on request.

out five and a half tons of dead fish.

So the city fathers at last girded for action: They authorized a $27,600,000 bond issue to set up a disposal plant that would treat the sewage and carry it into the Atlantic.

There was a catch to this proposal, though. Under Florida law, a majority vote for a general obligation bond issue doesn't make it legal. The law says that over half the registered property owners must have actually voted.

This minimum voting requirement has meant the downfall of many a proposed public improvement. And this time prospects looked bleak. The reason: Miami's sewage bond issue was to be voted on at the next primary election, on May 27, 1952—only two short weeks away.

Was there time enough for dramatizing Miami's desperate need? Could the necessary 31,350 property owners be brought out to the polls? More important, could they be sold on spending all that money—particularly when part was to be raised by doubling their water bills?

At this point, Miami's doctors reentered the picture. Having decided that the bond issue could be—in fact, had to be—put over, they mobilized fast. But by the time they were ready for the campaign, they had only ten days to go.

How They Did It

Thirty-three of Miami's best-known physicians—and most persuasive speakers—were chosen to lead the fight. Many others volunteered their services. But there just weren't enough roles for everyone to play. Time was too short.

The occasion called for a swift, concentrated blitzkrieg. So that's what the Dade County Medical Association gave the city: It bombarded Miami day and night with radio and TV talks and with spot talks at civic clubs.

Altogether, the doctors made sixty-one personal radio and television appearances. They participated in ten radio panel discussions and appeared on four of the daily "Tell Me, Doctor" series on a local station. They gave twenty-one five-minute radio talks. In addition, their recorded "spot" announcements were repeated again and again on all local radio stations.

They spoke not only as medical men responsible for the community's health, but as husbands and fathers. They pleaded for their own families as well as for the community. They

"Why *not* a tourniquet? He's got a nosebleed, hasn't he?"

NEW FLEXIBILITY!

The finest table ever designed to meet the varying needs of the general practitioner. The Ritter Universal Table requires a minimum of effort to adjust to any position. All types of patients are easily and quickly adjusted to a convenient examining position. *Motor-driven hydraulically operated base operates silently, rapidly, smoothly. A touch of the toe on the operating lever is all that is required for low position of 26½"—high position 44½". Equipped with adjustable headrest, perineal cut-out, stainless steel irrigation pan, adjustable knee rest, stirrups, and hand wheel operated tilt mechanism. Ask your Ritter dealer for a demonstration now.*

RITTER UNIVERSAL TABLE

MODEL "B"

TYPE 2

FOR ADVANCED EQUIPMENT LOOK TO

Ritter

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RITTER PARK, ROCHESTER 3, N.Y.

cited case histories—including their own.

There was Dr. Herbert W. Virgin, for example. He told a television audience of having fallen from his sailboat while crossing Biscayne Bay. Before he was rescued, he had swallowed a couple of mouthfuls of bay water. As a result, he said, he had spent five days in the hospital recovering from an upper respiratory infection—directly due to the intake of contaminated water.

Dr. John Tanous, a surgeon, warned Miamians that "a person undergoing surgery today with modern medical know-how takes less risk than he would take if he swam or went water-skiing in Biscayne Bay." And Dr. Frank T. Sheehan put that risk in specific terms: "Camping at our very doorstep," he said, "are such filth-borne diseases as typhoid, paratyphoid, dysentery, cholera, and possibly polio."

All the doctors emphasized the immediate danger of an epidemic. And, added Dr. Ralph W. Jack, president-elect of the medical society, "Should we have such an epidemic, our medical and hospital facilities might prove inadequate to cope with it."

Dr. Ned Annis, among others, played up the family health angle. As the father of six children, he said that he dared not let them swim or sail anywhere near their own home—"for we live in that wide area of the bay that's marked by a skull and crossbones."

As the doctors continued their fight, they were joined by other civic groups. And they learned from patients and friends that the campaign was bearing fruit. Many people admitted they hadn't given the local health hazard a second thought—till now. But finally they were aroused. It was, they agreed, their own doctors who had aroused them.

When the ballots were finally counted, it was obvious that the doctors had won a thumping victory. By a vote of five to one, Miamians approved the sewer bond issue. The doctors had helped pull some 40,000 property owners to the polls—nearly 10,000 more than the required minimum.

Following the election, the city commission officially thanked Miami doctors for their powerful aid. And Dade County Health Commissioner T. E. Cato added:

"I believe that the doctors of this community are responsible for the success of this election . . . The health department has been working without success toward this goal for many years. It was the physicians who got behind the issue *and put it over.*" END

Swallow Hard

In re the medication
That's used to treat the ill:
Sometimes, alas, the patient
Turns out to be the pill.

—MILDRED MASON

THE PRACTICABLE SOLUTION OF

obesity control

A patient on Obedrin Tablets can maintain a restricted diet, in comfort and lose excess weight fairly rapidly, without undesirable side effects.

Each Obedrin Tablet contains:

SEMOXYDRINE HYDROCHLORIDE, 5 mg.
(Methamphetamine Hydrochloride)
Suppresses appetite, elevates mood.

THIAMINE HYDROCHLORIDE, 0.5 mg.;
RIBOFLAVIN, 1 mg.; NIACIN, 5 mg.
Dose of these essential vitamins is adequate to supplement the 60-10-70 Diet, yet low enough to prevent stimulation of appetite.

ASCORBIC ACID, 100 mg.
A large dose, to help mobilize tissue fluids, so often a problem in obese patients.

PENTOBARBITAL, 20 mg.
To avoid excitation and insomnia; counteracts undesirable cerebral stimulation of methamphetamine. Does not diminish the anorexigenic action of methamphetamine.

A complimentary pad of 60-10-70 Basic Diet Sheets and a trial supply of Obedrin sent to physicians on request.

AND THE
60-10-70 BASIC DIET

S. E. Massengill
BRISTOL, TENNESSEE

Some Bonds Offer You Tax Shelter

You can save tax dollars on several types—but you may well need some expert advice in the process

● Dr. Stanley Otis looked up from a list of questions he was compiling. His wife, noticing his concentration, had asked, "What's the problem? Is it Walter Chase's appendectomy or Mrs. Park's asthma?"

"Neither," he replied. "It's a new method of cutting our income taxes. I've been talking to Tom Finley, who's an investment consultant; and he's been giving me some hints on tax-sheltering our investments. The other day, he outlined a few techniques for protecting capital yields. Now I'm pondering some further questions on the subject."

"Tax-sheltering?" said Mrs. Otis. "What's that?"

"It's a term applied to any investment that legally provides income, or a profit, in such a way that the return isn't subject to taxes—or, at least, not to exorbitant taxes."

"Sounds wonderful! What's the hitch?"

"I don't know yet," said Otis. "That's why I want to ask some more questions. Right now, I'd like to learn more about bonds, particularly the tax-exempt kind. According to Finley, they seem to offer both safety and tax-free income."

Later that day, the physician called on the investment consultant. "What's the story about those tax-exempt bonds?" he asked.

Finley smiled. "It's a big subject, but I'll try to cover the main points for you. First, what *are* tax-exempts?

"They're bonds issued by states, counties, cities, and so on; and they're called 'tax-exempts' because income from them isn't subject to Federal income taxes.

"Broadly there are two types of tax-exempt bonds:

"First, *general obligation bonds.* These are backed by the full taxing power of the issuer. Such bonds are, in effect, a first lien on all real and

---

By William J. Casey

**This is the second article on tax-sheltered investments by Mr. Casey, who is co-author, with J. K. Lasser, of a recently published research study of the subject. The first article [see October* MEDICAL ECONOMICS*] discussed general principles of tax-sheltering.*

How to treat Seborrheic Dermatitis of the scalp

simply, effectively

Here is an unusually effective, yet simple-to-use treatment . . . for your prescription only. *Selsun* Sulfide Suspension is applied while washing the hair, allowed to remain in contact with the scalp for a total time of five minutes, and then rinsed out. There are no nightly application ordeals to go through, no greasy preparations to discomfort the patient or leave stains on clothing and linens. It is recommended that *Selsun* be used twice a week for the first two weeks, but thereafter applications may be necessary only at intervals of one to four weeks, depending upon the severity of the condition.

Clinical reports of 400 cases[1,2,3] showed *Selsun* to be effective in 92 to 95 percent of cases of common dandruff, and in 81 to 87 percent of all cases of seborrheic dermatitis. Many of these patients had previously tried other scalp medications without satisfaction. Optimum results were obtained with *Selsun* in four to eight weeks, although itching and burning symptoms were alleviated after the second or third application in the majority of cases.

Extensive research on toxicity[1,2] showed *Selsun* to have no harmful effects when used externally as recommended. Available at pharmacies in 4-fluidounce bottles, *Selsun* is dispensed only on the prescription of a physician. Bottles have tear-off labels. Abbott

WRITE FOR LITERATURE on this outstanding new product.

Address: Dept. 021, ABBOTT LABORATORIES, North Chicago, Illinois.

References:

1. Slinger, W. N., and Hubbard, D. M. (1951), Arch. Dermat. & Syph., 64:41, July.
2. Slepyan, A. H. (1952), Ibid., 65:228, February.
3. Ruch, D. M. (1951), Communication to Abbott Laboratories.

PRESCRIBE **SELSUN**

TRADE MARK

SULFIDE *suspension*

(SELENIUM SULFIDE, ABBOTT)

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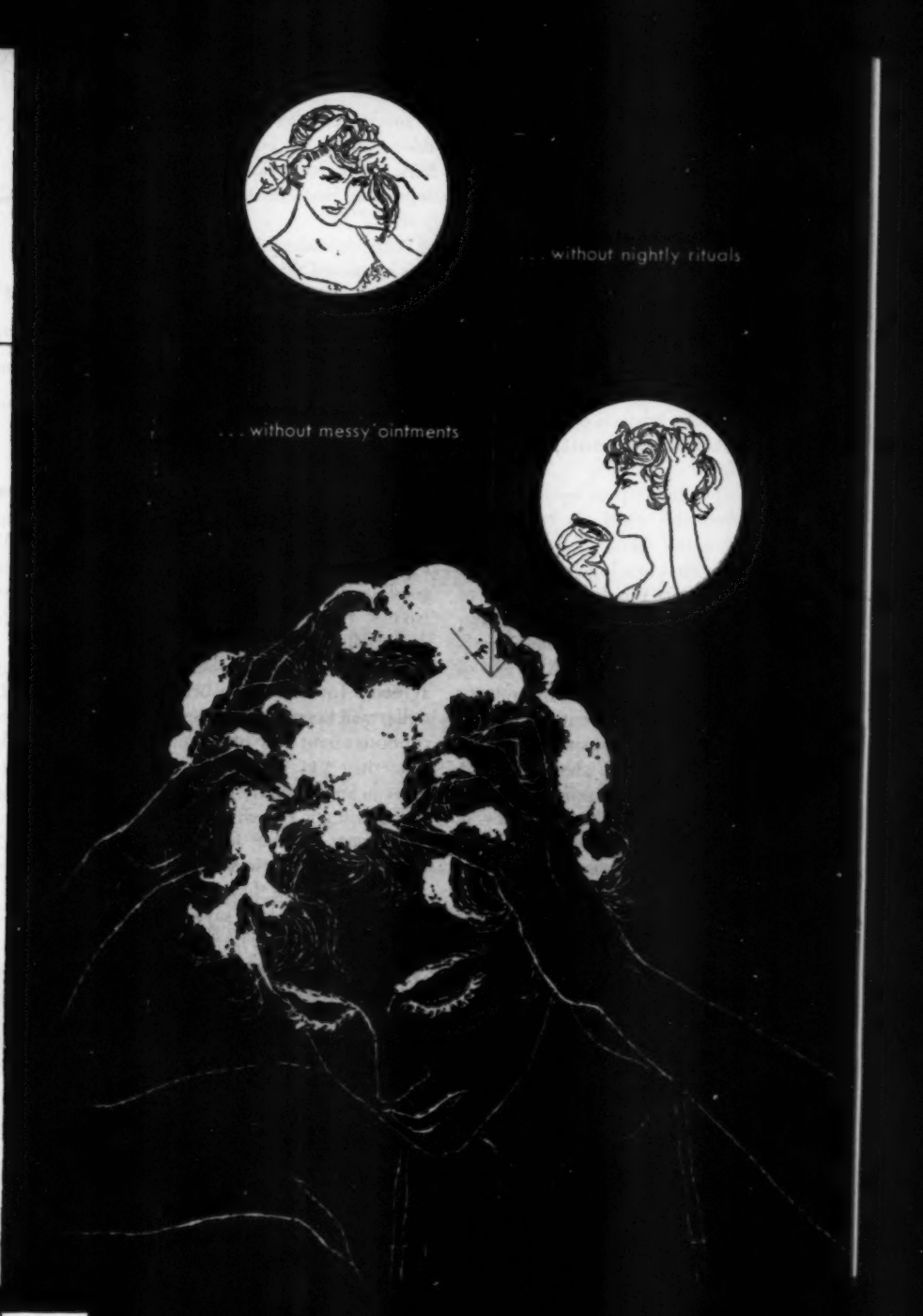

. . . without nightly rituals
. . . without messy ointments

personal property in the locality.

"Second, *revenue bonds.* These are issued to cover a self-supporting improvement, like a toll bridge, tunnel, or water system. They are *not* backed by the taxing power and assets of the locality.

"Because general obligation bonds are usually considered safer, the investor must pay a 'premium' for them. In other words, their yield is likely to be lower than that of revenue bonds. But you can find sound investment opportunities in both types.

"Depending upon quality and security, the yield of tax-exempt bonds varies from a low of about 1.25 per cent to a high of more than 3.5 per cent. But higher yields, of course, usually entail greater risks. The physician-investor should carefully examine bonds with a yield of 2.5 per cent and more. And returns of above 3.5 per cent should be viewed with some suspicion.

"At this point I should caution you: Don't try to appraise the degree of risk and the adequacy of yield of tax-exempt municipals without the advice of a specialist in the business."

Dr. Otis frowned thoughtfully. "But how can low-yield bonds compete with good common stocks that yield up to 6 per cent?"

Low Yield, High Income

"One word—*taxes*—is the answer," said Finley. He held out a sheet of paper. "Here's a table worth studying. It's a comparison of the yield an investor would need from a taxable security to equal his return from a 3 per cent tax-exempt bond, depending upon his income and tax bracket."

With considerable interest, Dr. Otis examined this chart:

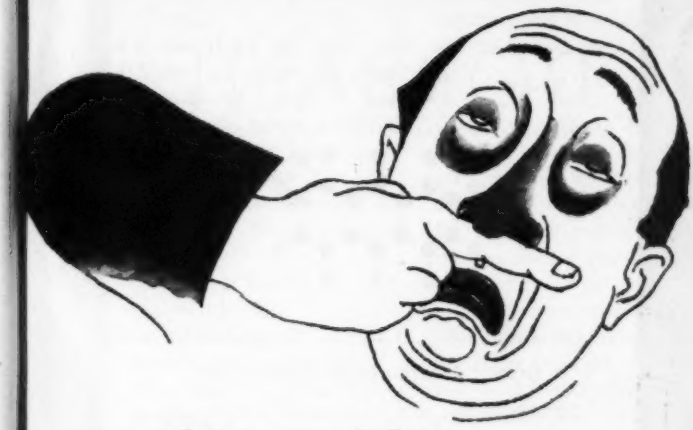
Taxable Income	Top Tax Rate	Yield Needed
$12,000	42%	5.2%
14,000	48	5.8
16,000	53	6.4
18,000	56	6.8
20,000	59	7.3
22,000	62	7.9
26,000	66	8.8

"Well, I think I get the picture," said the doctor at last. "But, frankly, I've been told that bonds aren't too good an investment these days. Isn't it true that inflation shrinks their dollar value at maturity?"

"That *has* been true," Finley agreed. "Investors who believe the dollar will keep on shrinking will be cautious about how much money, if any, they put into bonds. But no one can know exactly which way the dollar will go. The wisest move is to keep part of your investments in fixed dollar obligations (like bonds) and part in assets that appreciate as the dollar shrinks (say, common stocks or real estate).

"Naturally, investors are chary of tax-exempt bonds in inflationary periods. But there are, as you know, other kinds of bonds, too. And some of them not only have tax-shelter features but also provide a hedge against possible dollar shrinkage."

"That sounds interesting," said



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Each CORICIDIN® Tablet contains 2 mg. chlorprophenpyridamine maleate and the standard APC combination.

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Dr. Otis. "Tell me about them, will you?"

But Finley shook his head. "As I've said, it's a big subject. I'd rather not confuse you by going into it too deeply. I think it's probably enough for your purpose now just to know their names. There are five kinds you may want to remember for future reference." He ticked them off on his fingers:

"1. Convertible bonds;
"2. Discount bonds;
"3. Income bonds;
"4. Investment certificates;
"5. U.S. Government Savings Bonds.

"All these can provide some tax shelter," Finley went on. "But they're pretty complicated to try to explain in detail. The principle is similar in each of them, though; and that principle is this:

"Under certain circumstances, income from bonds of these five classes can be taken in such a way that your profits may be considered in effect as capital gains. Because of the lower tax rate that applies to capital gains, there may be a potential tax saving for you."

Word of Warning

Dr. Otis sighed. "But you haven't told me what the five types really are," he said. "You've simply named them. And I don't understand how I'd go about taking advantage of the tax-shelter features of any of them."

"Of course not," said Finley. "You'll need expert advice on them. But what I've told you should help you to evaluate that advice when you get it.

"Which brings up a point that I can't overemphasize," he added. "I'm not necessarily *recommending* any of these bonds we've been talking about today. I've pointed out that they do provide tax shelter but I urge you to find out about their other features as well. Some may suit your needs; others may not."

"Don't worry," said Dr. Otis, with a smile. "I'll go slow." END

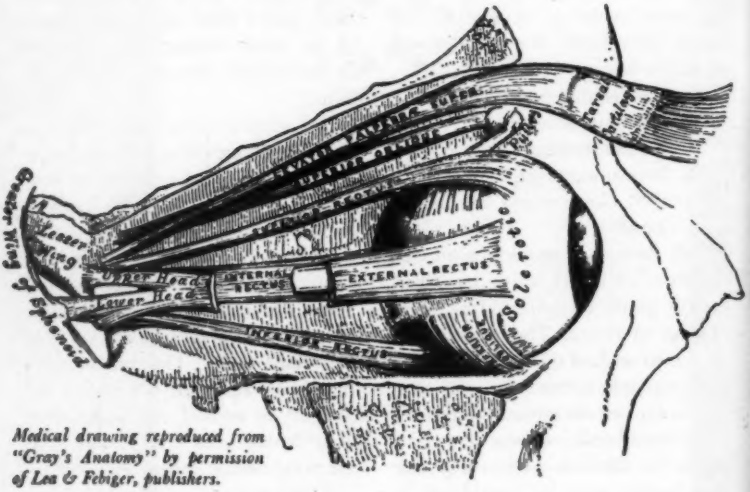
Minor Oversight

• A mother rushed into the waiting room of my pediatric office and plopped down in a chair with a "Whew!" of relief. After she got her breath back, she settled down to await her turn on the appointment schedule.

Then, suddenly, without warning, she burst into a fit of wild laughter. When my receptionist hurried over to ask what was wrong, she replied: "My God, I left the *baby* home!"

—WARREN R. TEPPER, M.D.

When a patient just can't see giving up coffee . . .



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Tell him about grand-tasting Sanka Coffee. It's 97% caffein-free . . . can't cause sleeplessness or get on the nerves.

SANKA

The perfect coffee for the patient affected by caffein.

Products of General Foods

Letters to a Doctor's Secretary

On the ethics of preserving secrecy, patient-stealing, loyalty, and advertising

By Anna Davis Hunt

● Dear Mary:

Some months ago I attended a luncheon in honor of a new bride. One of the girls there was secretary to an obstetrician who was just starting in practice. She was a lively, talkative person; and she sent the party into gales of laughter with an account of how her doctor had attended a woman several months for pregnancy before he discovered that she had—not a baby, but an abdominal tumor. Everyone was amused. But, needless to say, few of those present (or their acquaintances) will ever consult that doctor.

Talking shop outside the office can be dangerous as well as in questionable taste. My own policy, when I worked with Dr. Barrie, was to mention his name in social gatherings—but briefly. To any new acquaintance who asked what I did, I of course described the doctor and his work. I also spoke of him freely and enthusiastically to my family and friends.

But as for telling tales out of school—well, the only tales I told were ones that did credit to my employer. As you know by now, I had plenty to tell. Like this incident, for example:

Late one afternoon, when I was alone in the reception room, an old woman came in. She was poorly dressed, but neat and clean. Her broad, foreign face beamed with health. Timidly, she inquired in broken English whether she could see the doctor.

"Do you have an appointment?" I asked.

"No," she said, apologetically, "but I won't take much time. I—I just want to look at him."

Noting my surprise, she explained: "You see, Miss, three years ago he operated on me at the free clinic. I was dying when he came. I didn't

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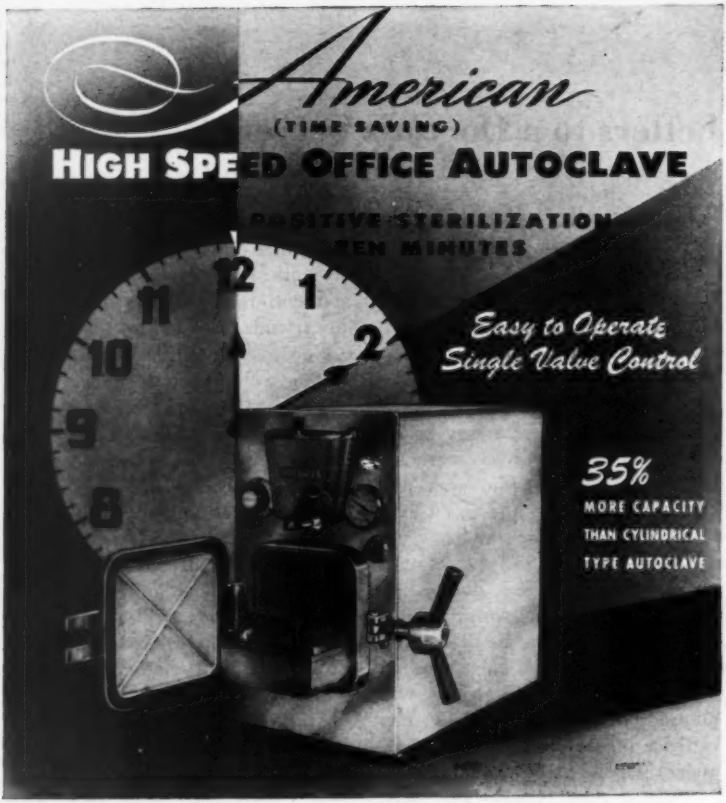
**These letters were published originally as a series in* MEDICAL ECONOMICS, *signed with the nom de plume Myrna Chase. In response to a great many requests, they are being reprinted in revised and updated form. The complete current series, of which the present letter is the fifteenth, is now available as a book.*



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know what was happening. They told me later that it was a hard operation. He was gone when I woke up. Others took care of me after. I got well. I am strong. I work again. He saved my life, but I have never seen his face."

The doctor was busy with a patient at the time; but when I told him what the old woman wanted, he stepped into the waiting room to speak to her. She seized his hands and covered them with kisses, the tears running down her cheeks. There were tears in my eyes too.

If you want to spellbind your card club and talk shop at the same time, *that's* the kind of story to tell about your doctor. Your tact and loyalty can have a real effect on his reputation.

Ethics for an Aide

Just last week, a friend of mine repeated the remark a physician's receptionist had made to him:

"Gee, so many awful things happen to people. When I have to listen to them all day, they sure get me down."

How's that for tact?

The receptionist's remarks and attitude are often the straw that tips the scales in favor of her doctor when a wavering patient can't quite decide to go through with a necessary operation or course of treatment.

People will often ask you, "Isn't it terribly depressing to work around sick people?" Your stock answer should go something like this: "Depressing? No, indeed. Dr. Barrie does so much good that it's a pleasure to be able to help."

We can say, then, that the first rule of ethics for a doctor's secretary is intelligent and constructive loyalty. A second—and equally important—rule is secrecy.

Not long ago, I was sitting in the crowded waiting room of one of our foremost internists when the receptionist called a telephone number and asked for Mr. X. Mr. X is a man widely known in the community. His name was probably recognized by everyone within earshot. When she finally got him, this is what she said:

"Mr. X, could you come over tomorrow at 5? It's about that Wassermann."

I hoped no one else in the room knew what she meant. But it's reasonably certain that some did. Before the day was over, they were no doubt whispering to their friends: "Mr. X has syphilis, my dear, and Dr. Y is treating him. Can you imagine it!"

That receptionist had carelessly flouted the rule of secrecy. Beware of making a similar mistake, Mary. As Dr. Barrie's aide, you type the patients' records. You know the facts behind hundreds of illnesses. You know why Mrs. A has left her husband, why certain organs were removed from Mrs. B, and why Mr. C has only a few months to live.

But you have those facts in trust! The secrecy imposed on you in cases like these is no less binding than the

in hypertension

TURASED

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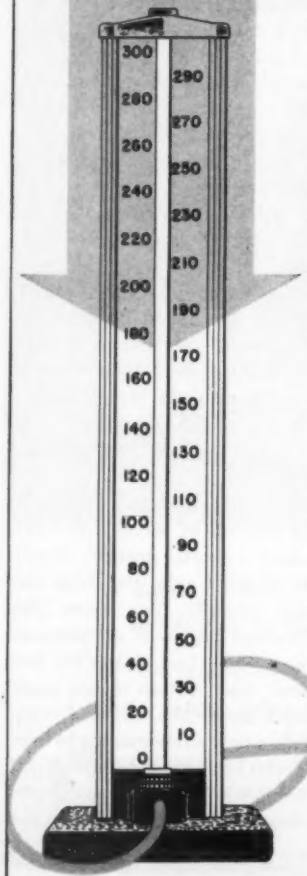

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1. Parsonnet, A. E., et al.: J. M. Soc. New Jersey 47:504, 1950.

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secrecy of the confessional. What the patient reveals to the world is his own business. You must reveal nothing.

If an inquisitive acquaintance says, "I hear Miss D has cancer. Is it true?" a good answer is: "Where *did* you get that adorable hat?"

When to Talk

You may freely give the details of a patient's case *only* to another doctor. If Dr. Barrie refers Mrs. B to a colleague, he sends along all the information he has on her case, and he expects a detailed report in return. Or if she consults another doctor of her own accord and asks Dr. Barrie to send him a résumé of her case, this must of course be done. All information about her is still sacred to herself and her doctors; there must be no leak to the outside world.

Sickness or accident benefit blanks from insurance companies, which the patient himself brings in, should be filled out, naturally. But aside from this, information should seldom be given to such companies without a written and signed request from the patient.

It's possible that you may sometimes get a phoned request, like this:

"This is the Colossal Insurance Company. Mr. Jonathan Doe is applying for life insurance and states that Dr. Barrie operated on him in 1936. Will you please let us know what operation was performed and what the prognosis was?"

To such inquiries you reply politely, "We'll be glad to do so if you'll send us a request signed by the patient."

It's surprising how often they'll try to argue. But you should answer, politely: "I'm sure you're right that it would make no difference in this case, but it's an established rule in our office and I'm not allowed to make exceptions."

This procedure should also be followed if an attorney or a newspaper reporter calls for information. And, of course, when people unknown to you say they're relatives or friends of a patient and ask for private information, you should be especially on your guard. You may even play ignorant, saying, "I'm sorry, I really don't know. Perhaps if you'd come in with the patient next time . . . ?"

There are definite legal aspects of this rule of secrecy. We don't need to go into them here, except to say that the rule operates for the mutual protection of patient and doctor. It might be violated a hundred times with no ill effects. But the one-hundred-and-first time might cause irreparable damage. So follow the rule regularly, and you'll never need to worry.

There are also many little careless ways in which secrecy may be violated; for example, the telephone conversation with Mr. X that I mentioned earlier. Have you ever heard a secretary in a surgeon's reception room call the hospital to make a reservation, giving the patient's name,

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Sick Children

The rapidity with which eggless rennet-custards are digested—so easily made from uncooked milk with "Junket" Brand Rennet Powder or Tablets—especially recommends them in the infectious and febrile diseases which so often plague the young. When intestinal secretions are insufficient and digestive capacity and appetite impaired, light, easily digested and attractive foods are particularly welcomed. You will be pleased with the manner in which nutritious rennet-custards, quickly prepared in a wide range of colors and flavors, help to combat the "vicious circle" of flagging appetite and lowered resistance in the debilitated child.

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diagnosis, and operation to be performed? I trust the very thought of it makes you shudder.

What Is 'Stealing'?

Our third rule of ethics can be phrased as a prohibition: Never "steal" a patient from another physician.

It would be easy for you to do this in perfect innocence if you weren't warned. Laymen are usually ignorant or resentful of this aspect of medical ethics. But it's not just a convention. If we analyze it, we find that it justifies itself by benefiting both patient and doctor.

Suppose a man is sick and decides to consult a physician. His choice of physician may depend on any one of a dozen circumstances. He may call someone a friend recommends. He may call a doctor he knows socially. Or he may simply consult the telephone directory.

But as soon as he has chosen a doctor and placed himself in his care, he is that man's patient. This is very different from employing, say, a day laborer.

After the doctor is employed, a careful examination must be made. There's an inevitable interplay of personalities. The physician sizes the patient up and reaches back through innumerable brain paths of knowledge and experience to the solution of the problem before him. The brief scene in the examining room depends for its validity upon thousands of hours of previous study and work. Is it fair to start up

"This is no time to be 'feeling better already.' We haven't even finished the diagnosis."

this complicated machinery, only to let it drop?

The patient often overlooks these facts. If he objects to the doctor's haircut or his fees, or if some well-meaning friend urges him to see *his* doctor, he may feel free to make a sudden change. Sometimes, he'll even desert the doctor just on the eve of a cure—a great waste of valuable time.

If a patient has given a physician a fair trial and still lacks faith in him, most certainly he's justified in changing. But he should then pay his bill and say he's going to discontinue treatment, *before* he seeks another physician.

It's the duty of every practicing physician to refuse to accept a patient from another doctor before that doctor has been dismissed or has himself given up the case. In the long run, the doctor who leans over backward in this respect will never lose.

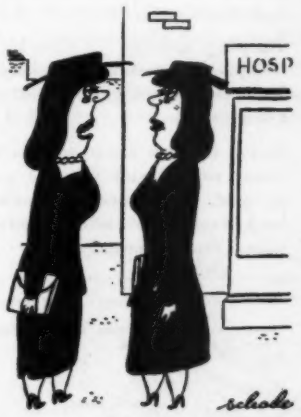
As the doctor's secretary, it's your job to be as discerning as possible in giving appointments to new patients. If you suspect they belong elsewhere, just give Dr. Barrie a tip. It's usually easy for him to find out, as he takes the history, whether the patient has been consulting another doctor. If he discovers that he has, he promptly telephones the other physician and asks to know the facts. He may then either send the patient back or refuse to treat him until the first doctor has been formally dismissed and paid.

In matters of consultation you have a little freer range. But you must still be careful. Only *another doctor* can call your doctor in consultation—a point unknown to many laymen. It's fairly common, for instance, for a woman to call up and say:

"My little boy has been sick for quite a while. My doctor says he needs an operation. But I've heard about Dr. Barrie and I'd like to know what he thinks before I decide. May I have an appointment today?"

It's then up to you to explain tactfully that she must tell her own doctor that she'd like another opinion, and she must ask him to call Dr. Barrie in consultation.

All patients who are referred to Dr. Barrie for operation or special work must, without fail, be sent back to the referring doctor when



"Since he got run over by a street car he's only my half-brother."

the work is over. At the same time, a full report of the findings must be mailed to him. Dr. Barrie is punctilious about this; he depends on you to check and double check.

The fourth and last rule to remember is that physicians of standing don't advertise—either in the accepted commercial sense or, negatively, by disparaging their competitors. This doesn't mean that it's unethical for you to keep your doctor's name in circulation in a number of little ways.

You may, for instance, keep a tray of his cards on your desk for patients to take. You may write appointment reminders on cards that bear the doctor's name and address. You may send out notes, letters, and reports on his letterheads as often as needed. You may establish friendly relations with the tradespeople and public servants in your building and neighborhood.

Of course, these are only details. The *real* key to a doctor's success is still to be found in the old verse from Scripture, "By their works ye shall know them."

Dr. Barrie is so attentive and thorough with every patient he treats that he has naturally built up a splendid practice. The satisfaction and affection of his patients and the respect and trust of his colleagues have placed him at the top of his profession. You could do no better than to make him your example in your own sphere of activity.

Affectionately yours,
Myrna Chase

How to Deduct for Depreciation

Here's a workable way to figure out tax deductions for wear and tear on your car, office, and equipment

● *"The Federal income tax is based upon net income of a specified period. The production of net income usually involves the use of capital assets which wear out, become exhausted, or are consumed in such use. The wearing out, exhaustion, or consumption usually is gradual, extending over a period of years. It is ordinarily called depreciation, and the period over which it extends is the normal useful life of the asset."*

This is the first paragraph of the Bureau of Internal Revenue's manual on depreciation. And it's the axiom from which the bureau derives all its rules for figuring the tax deductions you can take for wear and tear on your professional property.

Before we look at the rules, let's list some of the items subject to depreciation. These include:

¶ Your office, if you own the building—or any part of your home that you use as an office;

¶ All office furniture, including lamps, fixtures, rugs, and pictures;

¶ Your medical equipment, such as surgical instruments, X-ray machine, and examination table;

¶ Your professionally-used car.

For tax purposes, each of these has a life expectancy based on the length of time you can reasonably expect to use it before it wears out or becomes obsolete. For a brick structure, the useful life could well be forty years; for a frame building, twenty-five years; for an X-ray or typewriter, ten years; for an automobile, four years; and so on.

As a rule, you must determine the useful life yourself. But the bureau expects you to follow accepted practices. You can find a detailed ac-

By John C. Post and Peter S. Nagan

**Mr. Post is a professional management consultant in Washington, D.C. Mr. Nagan is* MEDICAL ECONOMICS' *Washington correspondent.*

Ease the squeeze of taxes!

count of these in the bureau's "Bulletin F," which is sold, at 25 cents a copy, by the Superintendent of Documents, Washington, D.C.

For most doctors, though, the table cited later in this article should be a sufficient guide.

Once you've decided on the useful life of an item, you may not arbitrarily shorten it for later tax returns. If, for instance, your car wears out in three years instead of the anticipated four, you'll need a good reason for any deduction change—say, unexpectedly heavy use.

Computing Deductions

When you've determined the useful life, it's easy to compute your annual deduction for any piece of professional property: *Simply divide the useful years of the asset into its cost.*

For example, your car may have cost you $3,000. Allowing it a useful life of four years, you'd thus have an annual deduction of $750.

One point to bear in mind, however: Almost every asset—even one that's worthless from a medical standpoint—has a salvage value at the end of its useful life. It may, for instance, be salable as scrap.

If you can estimate the salvage value, you may subtract it from the cost of the asset before figuring annual depreciation. If you can't estimate the salvage value, just take your full annual depreciation; then, when you get salvage money, you treat it as a long-term capital gain.

It's possible, of course, for your original estimate of the useful life of an asset to prove wrong. Sometimes an item becomes unexpectedly obsolete, and you're forced to get rid of it long before you planned to.

In this event, says the bureau, *you can immediately write off its undepreciated cost.*

Suppose, for instance, that a better X-ray unit hits the market this year, and that your five-year-old equipment—which originally cost $800—is only half depreciated. Suppose that you've already written off $400 and that you now realize $75 from selling the unit. In this case, you can take all the remaining $325 as a tax deduction for 1953.

List Your Assets

Remember that you may be asked to prove the validity of all deductions. *So be sure to keep clear and permanent records of every asset purchase.* Your files should show the cost and estimated useful life of every piece of professional property you own.

If you keep the records straight, you can then simplify your computations by *lumping together items of a similar nature.* These items don't have to be the same age; that is, you needn't have bought them all in the same year. Nor must they have identical useful lives. And there's no limit to the number you can include in any such group.

Lumping Saves Time

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Research to Serve Your Practice

sional assets into five main groups: (1) buildings; (2) safes; (3) scientific equipment; (4) mechanical equipment; and (5) furniture, fixtures, and filing cases. The buildings and safes groups may include only one item each. But the scientific equipment group may include dozens—among them, say, a surgical lamp bought four years ago, an electrocardiograph bought last year, and a brand-new X-ray machine.

Similarly, your furniture, fixtures, and filing case group may contain a fourteen-year-old desk, with an estimated useful life of twenty years, and some recently purchased carpets with an estimated useful life of ten years.

An Easy Formula

The bureau prescribes a useful life for each *group* of assets segregated in this way. The life of a building depends, of course, on its structure; but the four other groups of assets have useful lives recognized by the bureau as follows:

Safes	50 years
Scientific equipment	10 years
Mechanical equipment	8 years
Furniture, fixtures, and filing cases	15 years

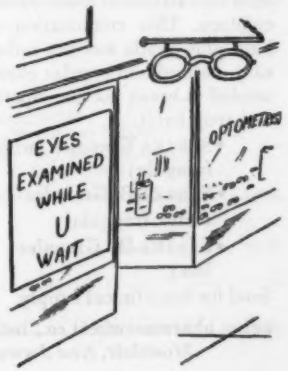
If you prefer *not* to group your depreciation deductions, the bureau will recognize the useful life of individual items of professional equipment as follows:

Automobile	3 to 5 years
Bookcase	20 years
Cabinet or file	15 years
Desk	20 years
Diathermy unit	10 years
Dictation machine	6 years
Fan or room air conditioner	10 years
Lamp	10 years
Linoleum	8 years
Locker	25 years
Rug, carpet, or mat	10 years
Safe	50 years
Settee	13 years
Surgical equipment	10 years
Typewriter	5 years
Water cooler	10 years
X-ray machine	10 years

As an example of how grouping works, let's suppose you buy the following equipment in any one year:

1 desk	$200
3 chairs @ $55 each	165
2 floor lamps @ $40 each	80
1 desk lamp	25
3 file cabinets @ $40 each	120
2 carpets @ $100 each	200
Total	$790

Since the composite useful life



schade

of furniture and fixtures is fifteen years, all you need do is divide the total cost by 15. Result: a total annual depreciation deduction of $52.67.

Saves Arithmetic

Apart from the saving in time, there's another advantage to grouping like this: When depreciation is computed item by item, the arithmetic is complicated by the fact that the write-off must start from the month of purchase. For items you don't buy in January (which is probably the start of your accounting year), you're entitled to only a fraction of the normal annual depreciation during the first year.

For example, if you bought a new typewriter early last April, you're entitled to only nine-twelfths of a full year's depreciation for 1952. Then, since its useful life is five years, you'll have to take three-twelfths of a year's depreciation in the sixth year.

But if you group items, you don't have to worry about such irritating fractions. You simply take the full year's depreciation on the total value of any group.

One last word: Remember that the cost of incidental repairs and of books, periodicals, or items costing only a few dollars can—and should—be written off as current expenses. Only a replacement or an addition that increases the life of an asset is regarded as a capital investment. And only on a capital investment may depreciation be deducted for tax purposes. END

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Partnership Practice: The Division of Income

[CONTINUED FROM 78]

behind. The two doctors agreed, therefore, on this division of income:

	Senior	Junior
First year	80%	20%
Second year	75	25
Third year	70	30
Fourth year	65	35
Fifth year	60	40

From the fifth year on, said their contract, the income division would be "as mutually agreed."

Case B: Two Detroit internists wanted to combine. One was 52 and a part-time professor; the other was 30, a former student of his. As in the previous case, nearly all income factors favored the senior—though not quite so overwhelmingly. Here's how the partners agreed to share their earnings:

	Senior	Junior
First year	75%	25%
Second year	70	30
Third year	65	35
Fourth year	60	40

Thereafter, the division would be "as mutually agreed," with the intention of moving the junior toward equality in jumps of 2½ percentage points a year.

He Owned the Clinic

Case C: A surgeon, 41, had a well-equipped clinic in a small Michigan town. He began to draw referrals from so many surrounding areas that he needed help. He broached the partnership idea to a 40-year-old general man with a special interest in surgery.

Here were two men of roughly the same age and experience. Yet other factors (notably, earning potential and ability to attract patients) dictated a fairly wide income spread between them. The result:

	Senior	Junior
First year	70%	30%
Second year	65	35
Third year	60	40
Fourth year	55	45
Fifth year	50	50

Expense-Sharing First

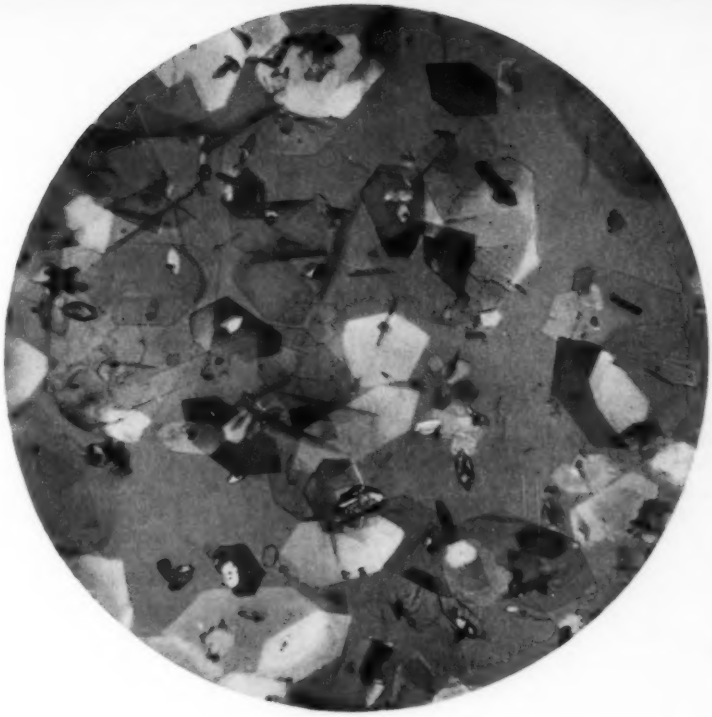
Case D: Two pediatricians in a medium-size Indiana city had been sharing office expenses. By the time they decided to become full partners, they had a pretty good idea of what each would contribute, both in talents and in patients.

These factors jibed with their ages (41 and 32) about as you'd expect. So their income agreement emerged like this:

	Senior	Junior
First year	65%	35%
Second year	60	40
Third year	55	45
Fourth year	50	50

Small-Town Team

Case E: Two general practitioners in a Wisconsin town of 1,000 agreed to join forces. Their income-sharing problem was simplified by the fact



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Because 'Paredrine'-Sulfathiazole is a suspension of Micraform* sulfathiazole crystals—rather than a solution—it is not quickly washed away. The Suspension's minute antibacterial crystals, which are deposited at the site of infection in a fine even film, remain on *infected* mucosa for hours. They provide prolonged bacteriostasis precisely where it is needed most.

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This is the fifth of a series of Norman Rockwell portraits, depicting patients typical of those you see in your everyday practice.

reassure this patient?

You doubtless use a certain amount of practical psychotherapy in treating every patient you see. In some cases just an encouraging smile or a reassuring pat on the back may get results. But all too often it requires far more of the physician's time and attention in order to give the patient the reassurance he needs.

Whatever methods of psychotherapy you may use, you will find 'Dexamyl' of unique assistance. 'Dexamyl' is a balanced combination of *two* mood-ameliorating components:

1. Dexedrine* Sulfate—the antidepressant of choice—to lift the patient's mood and provide a sense of well-being.
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that they were much alike in training, experience, and age. It was simplified even more by the fact that they were the only two doctors in town.

Thus, they could start sharing income in proportion to their existing practices, then equalize in a relatively short time. Here's how they arranged it:

	Senior	Junior
First year	60%	40%
Second year	55	45
Third year	50	50

Retirement Ahead

Case F: In a medium-size Michigan city, two ophthalmologists wanted to team up. One man planned to retire in four years; he was already 66 and had a large practice. The other man, 42, was also well-established, although he lacked the following of the older man.

How did they meet their short-term needs? Through an income schedule starting not far from equality, but approaching it more gradually than most:

	Senior	Junior
First year	57½%	42½%
Second year	55	45
Third year	52½	47½
Fourth year	50	50

Case G: Two urologists in Ohio faced a comparable situation: Although they were equals in most respects, one man had a slightly larger practice and was closer to retirement. Here's how these two doctors (aged 59 and 52) divided income when they became partners:

	Senior	Junior
First year	55%	45%
Second year	54	46
Third year	53	47
Fourth year	52	48
Fifth year	51	49
Sixth year	50	50

When Age Doesn't Count

Case H: In Chicago, two well-known surgeons decided to combine. One was 61, the other 44. Their age difference meant little, however, in view of their striking similarity on more important counts —e.g., professional standing and size of existing practice. Their income agreement:

	Senior	Junior
First year and thereafter	50%	50%

Case I: Two general practitioners in Indiana wanted to form a partnership. One man had twice the practice that the other had. At first glance, therefore, a big difference in their income shares seemed warranted.

But the older man (aged 45) had been working at a killing pace; he badly needed to slow down. What's more, the younger man (aged 37) was the energetic sort who could be counted on to take up the slack. So their income agreement was designed to encourage both developments:

	Senior	Junior
First year and thereafter	50%	50%

[MORE→

Case J: An orthopedic surgeon on the East Coast combined with an industrial surgeon. The first man, 41, was the junior by ten years. But his specialized training and high-fee practice were viewed as overriding factors. So here's one case where income equality was *not* the eventual goal:

	Senior	Junior
First year and thereafter	40%	60%

What Other Gimmicks?

So far, we've been illustrating the straight percentage division, without frills. But it's not uncommon for such arrangements to be supplemented by minimum clauses, withholding clauses, and the like.

At this point, therefore, let's take a look at the extra gimmicks that some partners write into their income agreement:

Consider the idea of a guaranteed minimum for the junior. If he's fairly new in practice; if his earning potential is unknown; if the partnership's first-year volume can't be estimated—under these conditions a straight percentage division might work a hardship on him.

Here, then, is how the younger partner can be assured a fair share:

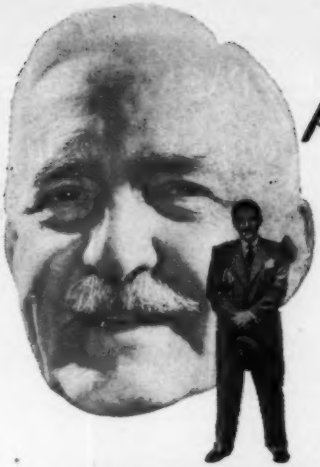
How to Support Junior

Case K: In a small Ohio town, a family doctor, aged 46, couldn't keep up with his obstetrical work. So he took on a 34-year-old OB specialist as his partner—the latter a man who had just begun practice in a neighboring town. They chose the income schedule shown below *with this proviso added:* The junior would be guaranteed at least $7,500 during each of the first two years.

	Senior	Junior
First year	65%	35%
Second year	60	40
Third year	55	45
Fourth year	50	50

Consider, too, the idea of a guaranteed minimum for the senior. Though seldom encountered in actual practice, such a plan can be used to protect the older physician from taking a loss when the partnership starts. And thus protected, he can offer the junior a much higher percentage share than usual. For example:

Case L: An established G.P. in Illinois brought in a younger colleague from another state. The founding partner hoped to clear at least as much as he had in solo practice—about $25,000 net. At the same time, he wanted to give the junior a strong incentive. For the first two



prescribed for a lifetime...

NEOHYDRIN®

THE DIURETIC TABLETS THAT WORK LIKE AN INJECTION

lifetime therapy—

NEOHYDRIN helps keep the cardiac patient in fluid and electrolyte balance for his lifetime—a lifetime that might be impossible without such control of water and salt metabolism.

day in, day out diuresis—

NEOHYDRIN daily, maintains a steady, uninterrupted diuresis. This allows more liberal salt intake which benefits the patient psychologically. Even more important, liberalized salt intake permits the daily physiologic intake and output of sodium required by the body and safeguards against salt depletion.

how to use this new drug

Maintenance of the edema-free state has been accomplished with as little as one NEOHYDRIN Tablet a day. Often this dosage of NEOHYDRIN will obtain per week an effect comparable to a weekly injection of MERCUHYDRIN.® When more intensive therapy is required one tablet or more three times daily may be prescribed as determined by the physician.

Gradual attainment of the ultimate maintenance dosage is recommended to preclude gastrointestinal upset which may occur in occasional patients with immediate high dosage. Though sustained, the onset of NEOHYDRIN diuresis is gradual. Injections of MERCUHYDRIN will be initially necessary in acute severe decompensation.

Contraindicated in acute nephritis and nephrosclerosis.

Any patient receiving a diuretic should ingest daily a glass of orange juice or other supplementary source of potassium.

prescribe NEOHYDRIN when indicated in

congestive heart failure • recurring edema and ascites • cardiac asthma • hypertensive heart disease dyspnea of cardiac origin • arteriosclerotic heart disease • fluid retention masked by obesity • and, for patients averse to their low-salt diet.

packaging **Bottles of 50 tablets. There are 18.3 mg. of 3-chloromercuri-2-methoxy-propylurea in each tablet.**

Leadership in diuretic research

Lakeside LABORATORIES, INC., MILWAUKEE 1, WISCONSIN

Now, new Donnatal form provides

DEPENDABLE SPASMOLYSIS *plus* Effective B-Complex Therapy

Product Name: **Donnatal Plus**

Characteristics: Combines spasmolytic and sedative actions of Donnatal's natural belladonna alkaloids with phenobarbital, *plus* a full therapeutic quanta of important B-complex factors, in three tablets daily.*

Clinical Aspects: Provides effective spasmolytic therapy *plus* corrective therapy for coexisting deficiencies of important B-vitamins.

In fatigue states associated with abnormal carbohydrate metabolism, belladonna alkaloids protect pancreatic islet tissue from vagus overstimulation; phenobarbital decreases psychic factors; B vitamins stimulate appetite and improve absorption and utilization of food.

Helps control gastrointestinal side effects of orally administered antibiotics.

Appearance: Green, sugar-coated tablets.

Supply: Bottles of 100 and 1000.

A. H. ROBINS CO., INC.
RICHMOND 20, VIRGINIA
Ethical Pharmaceuticals of Merit since 1878

*Usual daily dose

plus

Donnatal Tablets

Donnatal Capsules

Donnatal Elixir

Robins

DONNATAL PLUS

Enriched with B Complex

years, this was their arrangement:

The senior would be entitled to take $20,000 out of partnership earnings each year. What was left *—the balance only*—would then be divided thus:

	Senior	Junior
First year ...	33 1/3%	66 2/3%
Second year .	33 1/3	66 2/3

Note that this was a getting-started arrangement only. Two years later, the partners switched to an orthodox income schedule.

What about minimum drawings for *both* senior and junior? They're sometimes possible. But they're not practical unless the partnership's volume can be estimated in advance. Here's an illustration:

Case M: An ENT man in Indiana hired a junior assistant. Fifteen months later, the two men agreed to form a partnership. Their experience together had given them a good line on what total earnings to expect—at least $40,000 net, by all the signs. So they decided on this income-sharing plan:

The senior would be entitled to take $30,000 out of partnership earnings each year; the junior would be entitled to take out $10,000. What was left—*the balance only*—would then be divided thus:

	Senior	Junior
First year	50%	50%
Second year	50	50

Thereafter, they agreed, the percentages would remain the same, but the junior's minimum drawings would be increased.

One income gimmick that may have more drawbacks than advantages is the withholding clause. When this is added to a percentage agreement, part of the junior's share is placed in trust for him. The aim, of course, is to keep the younger partner from prematurely breaking away. Here's how the plan works:

Case N: A family doctor in the South promoted his salaried assistant to full partnership. The senior was 58, the junior 29. Anxious to have the combination last, the older physician insisted on the income schedule shown below *with this proviso added:* One-tenth of the junior's share each year would be withheld and placed in a trust fund.

	Senior	Junior
First year	75%	25%
Second year	70	30
Third year	65	35
Fourth year	60	40
Fifth year	55	45

What's wrong with this plan? In effect, it penalizes the junior wheth-

"I'm a nose and throat man . . . Now, don't take advantage of me."

NEW....

effective control of secondary complications
prompt relief of symptoms

White's

A-P-Cillin

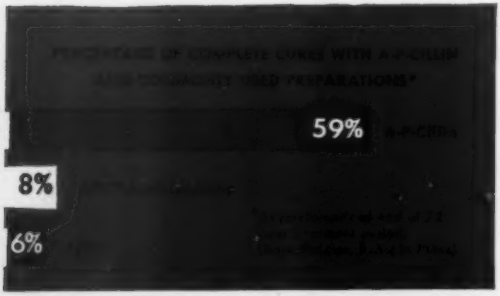
A-P-Cillin, its efficacy substantiated by clinical investigation,* is specifically designed for more effective management of one of the most frequent causes of human morbidity today—acute upper respiratory infections including the "common cold." A-P-Cillin is a therapeutic combination of penicillin, antihistamine and aspirin-phenacetin-caffeine to relieve distressing nasopharyngeal and constitutional symptoms and prevent secondary complications.

Each A-P-Cillin Tablet contains:

Procaine Penicillin G		100,000 units
APC	Acetylsalicylic Acid	2½ gr.
	Phenacetin	2 gr.
	Caffeine	½ gr.
Phenyltoloxamine Dihydrogen Citrate (antihistamine)		25 mg.

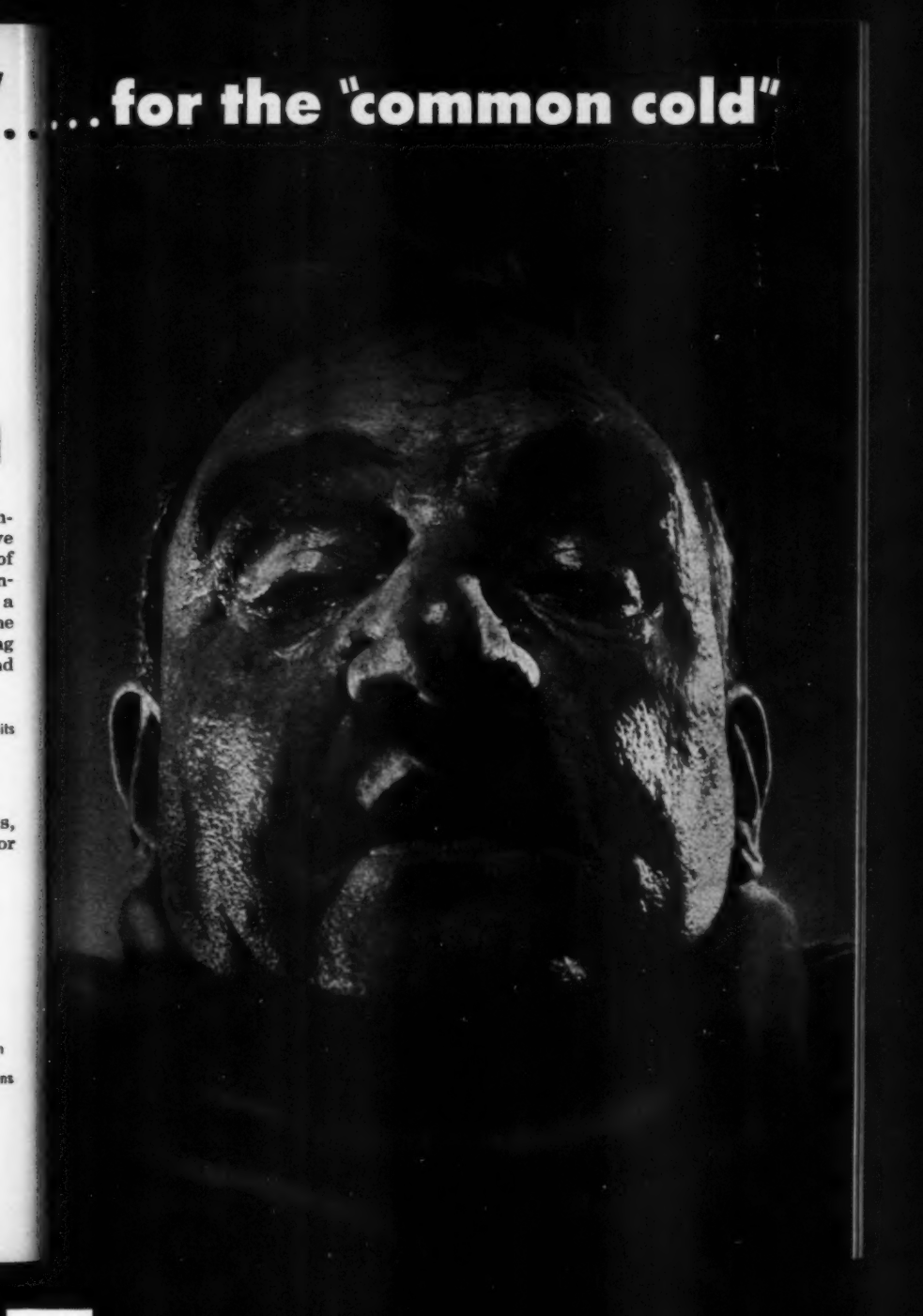
dosage: 2 tablets, t.i.d. for the duration of symptoms, preferably administered at least one hour before or two hours after meals.

White Laboratories, Inc., Kenilworth, N. J.



Bottles of 50 tablets

*McLane, R.A.: Clinical Evaluation of Combined Drug Therapy in Acute Upper Respiratory Infections (in press).


. . . . for the "common cold"

he breaks away or not. It withholds some of his earnings at the time he needs them most. And it withholds them even though he has to pay taxes on them.

We feel it's better *not* to penalize him during the life of the partnership, but only if he contributes to its demise. This can be arranged through a waiver clause—an agreement to waive his share of the accounts receivable if he dissolves the partnership. (It's a stiff penalty, since a typical two-man combination may have $20,000 on the books. But the point is, it's not ordinarily invoked.)

Enter the Third Man

Having just about run the gamut of two-way income division, we won't linger over three-way splits. The principles are the same. So, as a rule, are the relations between the two oldest partners. The only problem is scaling down their percentages to provide for the third man.

Here's how a brace of partnerships handled the three-way split:

Case O: An internists' group on the West Coast was dominated by the senior. He was 57; the other two were 41 and 36. He had the biggest reputation and earning power; the other two had small chance to catch up. All this was reflected in their income agreement—a fixed percentage division "until changed by mutual consent":

	Senior	Junior	Junior
First year and thereafter ..	55%	27%	18%

Case P: After sharing income equally for eight years, two OB men in Wisconsin decided to take on a third man. The new partner was 35; the original partners were both 47. Their income schedule for the first three years:

	Senior	Senior	Junior
First year	42%	42%	16%
Second year ..	41	41	18
Third year ...	39	39	22

Drawing-Account Problem

One final question remains: How do partners draw out the income that's due them? If exact shares aren't known until the end of the quarter (or perhaps until the end of the year), what do the doctors do for spending money in the meantime?

The most satisfactory arrangement is apt to be this:

At least once a month, they pay all partnership expenses. Then they transfer to reserve accounts the funds needed for tax installments, insurance premiums, asset replacements, and such. Finally, they divide up most—but not all—of what's left, *in the same ratio as their current percentage division.*

Most partners find it safest not to permit separate withdrawals—the raiding of the kitty by one doctor without a proportionate share going to the other(s). It's a sure-fire source of budget trouble. And if *both* of two partners raid the kitty, without thinking of cash reserves, only an accountant or business adviser can save their partnership. END

Winter Driving's a Pleasure!

Anyhow, says this skeptic, it may be—if all these new gadgets really work

● Until recently, I was sure there wasn't much I could do about winter driving except suffer in silence. If I couldn't think of an excuse to stay home—and how could I, with ailing patients all over town?—I had to expect the worst.

A few weeks ago, however, I found myself browsing around an auto-accessory store. And the more I browsed, the more astonished I became. There are, I discovered, dozens of gadgets designed to fight the elements and to solve the very problems I'd thought insoluble.

To illustrate, let's ponder five drawbacks to pleasurable winter driving. And let's compare my ice-

By Joseph Robinson, M.D.

Oops! Wrong again! The newspapers predicted snow—so here we have the author trying to remove chains after a sudden thaw. Despite the trunkful of streamlined accessories, he feels that winter driving is best done by bus.

age method of attacking them with the modern, streamlined way.

Door Lock Freezes

When the lock of my car door freezes, I usually deliver a few well-aimed kicks. This, of course, merely adds to last year's collection of dents. Next, remembering a suggestion I once read in MEDICAL ECONOMICS, I try heating the key with matches (the idea being to jiggle the warm key in the lock, thus thawing out the mechanism). This, while useful, doesn't always work, either; for if it's cold enough to freeze locks, it may also be windy enough to blow out matches.

Still, I like to try this method. It warms a fellow up to heat the key in a sheltered place, run to the car, jiggle the key until it cools, then run back to shelter and repeat the process. (When my matches give out, I can always hail a taxi.)

But maybe things will be different this year. I've bought a pocket-size device, powered by a chemical cartridge, that shoots something called jet steam (whatever that is) into the frozen lock. It cost only $1; and even if it's a dud, there's a key chain attached to the case that may come in handy.

Engine Won't Start

A reluctant power plant can be a real catastrophe when a snowbound patient wants me in a hurry. To guard against it, I've sometimes wrapped a blanket around the engine on cold nights. But though this worked with Old Dobbin fifty years ago, it doesn't always do the trick with a '49 Buick.

Fortunately, there are now quite a number of engine-warming devices on the market. They cost anywhere from $2 to $5; and they range from a kind of smudge pot that hangs under the hood to various electric heaters that fit into the cooling system or into the oil dip-stick hole.

I've actually invested in the smudge-pot deal. But so far I haven't tried to light it. I keep having dreams of a 3,800-pound bonfire in my garage. Maybe when the mercury dips to an unreasonable low, I'll give the car my electric blanket and pull an extra dog over my feet.

Windshield Ices Up

It sometimes helps, I've found, to cover the windshield with a couple of squares of cardboard if I leave the car out in a storm. Trouble is, I usually don't have any cardboard at the crucial moment. Besides, cardboard has a nasty habit of freezing to the windshield when it gets wet.

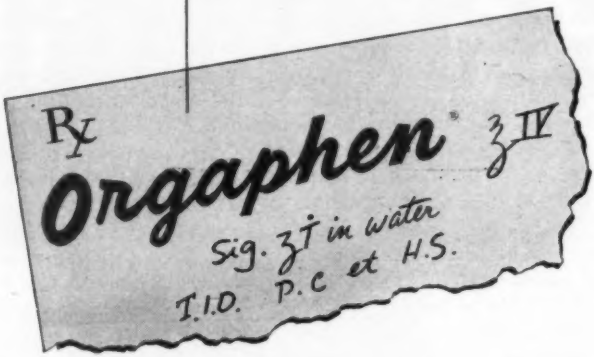
So now I've bought (for about $1) one of modern science's latest gifts to the winter motorist. It's a plastic cloth that stretches tightly across the windshield; you fasten each end by closing a door on it. Seems an eminently satisfactory device—though I'm afraid I'll forget to put it on until *after* the snow falls.

Even if ice does form, the gadget-manufacturers offer an easy way out. Now on the market, I find, is a

in hypertension...

FIRST: *Relieve the tension... Raise the spirit*

THEN: *Lower the Blood Pressure... ease the Symptoms*



Relief of the subjective symptoms accompanying high blood pressure may completely rehabilitate a hypertensive patient. Whereas, *mere lowering of blood pressure without relief of symptoms*, serves no such purpose.

The patient receiving ORGAPHEN WAMPOLE experiences relief of the disturbing subjective symptoms. A fall in blood pressure usually follows this subjective improvement.

ORGAPHEN WAMPOLE, the unique elixir of *organically bound iodine* and phenobarbital, has become a useful tool in the management of hypertension.

Each 4 cc. (teaspoonful) contains:

ORGANIDIN® Solution (organically combined iodine) .	10 minims
PHENOBARBITAL	⅛ grain

The low effective dose of the small quantity of phenobarbital in ORGAPHEN is *potentiated* by the *synergistic* action of ORGANIDIN. The *smaller* dose of phenobarbital tends to preclude neuroses frequently resulting from the larger doses more commonly employed.

Supplied in 16-oz. bottles.
Samples and literature on request.

HENRY K. WAMPOLE & CO. • PHILADELPHIA 23, PA.
INCORPORATED

Am. J. Med. *4*:875, 1948. Slaughter, Donald; Grover, Wm. C., and Hawkins, Richard. Report to American Therapeutic Society, Boston, 1950.

spray-on liquid that's supposed to be sure death to ice on windshields. There's also a tricky new windshield-wiper blade that drips anti-freeze on the glass. Both gimmicks are moderately priced; but not having tried them, I can't promise they'll work.

Snow Clogs Driveway

The obvious way to attack a snowbound driveway is with a snow shovel. I once read that snow slides off a shovel easily if you first rub soap or wax over the blade. But snow always seems to slide off somebody else's shovel better than off mine. Nor have I had much success at selling my teen-age son on the muscle-building qualities of shoveling snow.

But once again science has come to the rescue of the harassed driver. So now I'm torn between (1) a snowplow that's specially designed for passenger cars; (2) a gasoline-powered snow remover that you push like a power lawn mower; and (3) a steam-heating system for under the driveway that melts the snow as fast as it comes down.

Unfortunately, each of these devices is expensive; moreover, each has other drawbacks: Running that passenger-car snowplow would sorely tax my mechanical skill, I'm sure. The lawn-mower-type gadget would mean one more engine to start in cold weather. And the heating system could be installed only by ripping up the asphalt driveway I put in last summer.

Car Gets Stuck

In my city, traffic lights are carefully arranged to turn red as I approach each uphill corner. As a result, I often get stuck in an ice rut just when I'm in a hurry to make an important house call. So I keep a couple of pails of sand and a short-

"I must say, you medical men know how to relax"

1. immediate 2. sustained 3. prolonged reduction in blood pressure

Capsules RAY-TROTE combine three supplementing therapeutic agents which serve to control high blood pressure with maximum efficiency.

NITROGLYCERIN: Because of its rapid vasodilating action, nitroglycerin reduces blood pressure almost instantaneously.

SODIUM NITRITE: Sodium nitrite is a somewhat slower acting vasodilator, and begins to take full effect as the action of nitroglycerin subsides.

VERATRUM VIRIDE: Veratrum viride is probably the most active and reliable cardiac depressant. Although slow to act, its depressant effect on blood pressure is prolonged, exceeding that of sodium nitrite by several hours.

Consequently, capsules RAY-TROTE provide, in a single dosage form, immediate, sustained and prolonged therapeutic activity.

NOTE: *Raymer veratrum viride is both chemically and physiologically standardized (see kymograph tracings) to insure uniform action.*

PHENOBARBITAL: Capsules RAY-TROTE also contain phenobarbital, to maintain a calmer, more restful hypertensive patient.

DOSAGE: One capsule every three or four hours. Discontinue use if pulse becomes abnormally slow, or patient complains of nausea.

3-stage action
to control hypertension

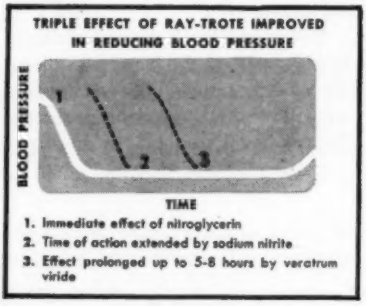
RAY-TROTE

Capsules Improved

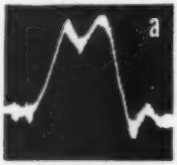
Formula: Each capsule contains:

Nitroglycerin	0.25 mg.
Sodium Nitrite	30 mg.
Veratrum viride (standardized to 1.0% alkaloid content)	65 mg.
Phenobarbital	15 mg.

Supplied in bottles of 100, 500 and 1,000 capsules. Also available, Capsules RAY-TROTE *with Rutin. In addition to the* RAY-TROTE *formula, each capsule contains* Rutin, *20 mg.*



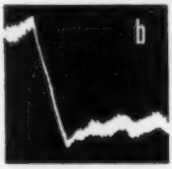
1. Immediate effect of nitroglycerin
2. Time of action extended by sodium nitrite
3. Effect prolonged up to 5-8 hours by veratrum viride

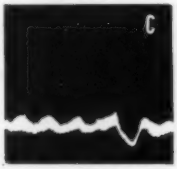


a. Pressor response to carotid sinus reflex (in dog) during control period.

b. Injection of Raymer standardized veratrum viride effects marked (57%), and almost instantaneous, fall in blood pressure.

c. Raymer standardized veratrum viride completely abolishes pressor response to carotid sinus reflex providing a conclusive physiological measure of therapeutic hypotensive activity and uniform potency of the drug.





RAYMER

RAYMER PHARMACAL COMPANY
Pharmaceutical Manufacturers
Jasper and Willard Streets, Philadelphia 34, Pa.

Serving the Medical Profession for a Third of a Century

handled shovel in the trunk. A little sand thrown around the rear wheels generally gets me going again. Also, I'm told, the weight of the sand gives the wheels better traction.

But I'm just a horse and buggy doctor, say the gadget manufacturers. They now offer some far more impressive solutions to the icy-road problem. One is a specially compounded grit that allegedly has twice the traction power of sand. Or you can buy a couple of rubber-cleated mats to slip under the wheels when you hit an ice patch. Or there are steel tire tracks that work in about the same way.

Perhaps you've noticed that these gimmicks have a common failing: They all require you to step out into the brisk, cold, sloppy weather, unfreeze the lock on your trunk, expose yourself to passing traffic, and so on. For that reason, either they're retrogressive or I am. The gimmick that appeals most to my pushbutton-conditioned mind is a technological triumph that sands the road as you drive along. It squirts gritty stuff under the wheels at the flick of a switch. Cost? Only sixty bucks (installation extra, of course).

I have no notion what science will come up with next. I like to dream of a ray that fits on the front bumper and melts the snow as I zoom ahead. Or perhaps a road surfacing that will prevent snow from sticking to it in the first place.

Until then, with all due respect to the new gadgets, I still believe that winter driving can be fun—when you do it along an avenue of palm trees. END

First-Hand Rapport

● During a much-needed vacation from my job as a doctor's receptionist, I stopped at a soda fountain for a noonday snack. On the next stool sat a well-dressed, middle-aged man. Soon he began to chat and before long had launched into a detailed account of his gout and other assorted ailments.

I'm afraid I became a bit annoyed. "I'm sorry you feel so bad," I said as politely as I could, "but I work in a doctor's office and have to listen to complaints from sick people all day. Since this happens to be my vacation, I'm trying to forget such troubles for a while. So, if you'll excuse me . . . "

"I know just how you feel, young lady," he interrupted, with a sigh. "*I* have to listen to people complain all day, too. But nobody ever listens to me. Like your employer, I'm a doctor also."

—THELMA LURRY

Almost everybody now living within twenty-five miles of the West Virginia mountain town of Pickens (pop. 500) was delivered by **James Lancashire Cunningham.** Since 1891, Dr. Cunningham has been the only practitioner in this farming community. Although he has delivered more than 3,500 babies, he says he hasn't lost a single mother in childbirth. At 89, Dr. Cunningham still drives an ancient Ford, has never failed to answer a house call, and even in hot weather wears his jacket and vest, "to uphold the dignity of the profession."

Time to Retire? Not for These M.D.'s

They're still going strong after more than half a century of active practice—and they don't plan to quit

● Is there an upper limit to the retirement age for M.D.'s? Apparently not. At 96, for example, an Iowa physician still treats patients in his office and makes country calls. And scores of other U.S. doctors, after practicing fifty to seventy years, also refuse to fade away.

"Retire?" says an elderly Georgia G.P. "It would suit me fine to pass out at the bedside of a patient." Provided, he adds, that it wouldn't upset the patient.

Why do they keep on working? How do they handle their practices? Why do many patients go to them rather than to younger doctors?

The experience of these active doctors in the upper-age brackets may be heartening news for younger

By James C. Fuller

men who look ahead, perhaps apprehensively, to their own R-Day. So MEDICAL ECONOMICS has asked a cross section of the oldsters to answer the above questions, as well as a few others. Their responses have been both spirited and inspiring.

Among the reasons they give for staying in harness:

¶ "I wanted to go on eating."

¶ "I love the work and I'm able to do it."

¶ "My patients won't let me stop. I seem to be needed."

¶ "I'm the only doctor in town now. I can't let these people down."

Planned Slow-Down

Doctors well past the meridian naturally don't try to work so hard as they did when they could deliver three babies a day in different parts of the county. Many a physician in his seventies decides that he'll leave night calls, at least, to younger men.

A fairly typical old-age routine is that of an Oklahoma G.P. who has been in practice sixty-four years. Recently he moved his office into his home "so as not to tax myself." Daily he works five or six hours, has some ten office visits, and makes perhaps three or four house calls. "My medical practice now," he reports, "is relaxation and fun." Yet more than one doctor approaching ninety rises at 7 A.M., works all day, and keeps evening office hours until 8 or 9 o'clock.

Some oldsters aren't sure that their patients *prefer* them to younger doctors. "They probably come to me out of sympathy," one of them

[MORE ON 190]

A visit to the Mayo Clinic in 1908 convinced **Charles F. Menninger** that group practice was what medicine most needed. When he failed to sell his colleagues on the idea, he decided to make doctors of his sons Karl and William (then in knee pants), in the hope that they'd someday join him in setting up a clinic. They did. And the Menninger Foundation is now the country's largest resident training center for psychiatrists. Dr. "C. F.," at 90, still runs it with his well-known sons. Besides acting as chairman of the foundation's board, he conducts therapeutic classes in horticulture, mineralogy, and conchology.

George E. Houck, 87, can look back on a distinguished career that began with a year of practice on an Oregon Indian reservation in 1891. During World War I, he was an Army doctor on the Mexican Border and in France. He has been Mayor of Roseburg, Ore., where he still practices. And he is a former president of his state medical society and of his state board of health. A pioneer in Oregon medicine, Dr. Houck is credited with having installed the state's first X-ray unit (in his office, in 1903). But he still feels that "the power of suggestion is often the only effective element in the treatment of a case." His advice to younger doctors: "If a patient comes into the office depressed, don't let him leave depressed. Talk him out of it. That may be all he needs."

Since there were no hospitals near Bay Shore, Long Island, N.Y., when he began practice there fifty-two years ago, young **George S. King** organized a mobile surgical team. A trained nurse went ahead to set up home operating rooms. Then, under lights rigged from the acetylene equipment of early cars, Dr. King and an assistant performed the operations. Today, 74-year-old Dr. King has his own 40-bed clinic and hospital, where patients who are unable to pay have their statements marked "C.T.G." This, says Dr. King, means "Charge to God. I've always tried to maintain a credit balance with Him." A prolific writer for medical journals, Dr. King has also been successful at nonmedical writing. His novel, "The Last Slaver," for example, was made into a movie called "Slave Ship."

says. But most feel that their present adequate practice is merely the natural harvest of a long career of family doctoring. For example:

"Many of my patients say they feel more secure in having me take care of their illnesses because I've known them since the day they were born. Also, they've told me it's hard to get younger doctors to cater to their health day and night."

But the family doctor approach isn't the only guarantee of a good lifetime practice. One elderly M.D. who runs his own clinic and has plenty of patients, old and new, gives this wry-crisp explanation of his continued success:

"My patients realize that I'm more interested in them than in their pocketbooks. We don't try experiments, and we don't keep patients running for hypodermic medication that can be administered by tablet."

At first glance, a doctor's chances of growing old in harness seem best if he's a G.P., since there are few specialists among the active oldsters. Is this bad news for the working-life expectancy of the specialist? Not necessarily. It merely means that when these G.P.'s set up practice in the 1880's and 1890's there were few specialists to grow old along with them. In fact, 90-year-old Dr. Charles F. Menninger recalls that when he began general practice in Kansas, the profession had "no specialists except surgeons and EENT men; and they too did general practice to earn a living."

In those days, the average doctor evidently had to be a jack of many trades, including horse trading, optometry, and basic dentistry. According to 90-year-old Dr. C. S. Smith, of Bozeman, Mont., "If a patient came into the office with a toothache, we pulled the tooth; if

[MORE ON 195]

An inveterate attender of medical meetings, **Edmund B. Montgomery,** of Quincy, Ill., joined the A.M.A. in 1880 and has a full set of badges from A.M.A. annual meetings since that date. He's also a charter member of the American College of Surgeons; and, at 93, he's the oldest living alumnus of Jefferson Medical College, Philadelphia. His special subject for sixty years, on which he now feels he can speak with some authority: geriatrics.

When, in 1888, **William L. Vroom** set up general practice in Ridgewood, N.J., his first case was a tooth extraction, his second a duck with a broken leg. Later, for the convenience of more conventional patients, he built himself a telephone, stringing the wires and leading them to the town's focal point, the general store. By the time he bought his first automobile (in 1908), he had retired his twenty-eighth horse to pasture. "In my day," says Dr. Vroom, who is now 86, "a doctor was very jealous of his practice, but there was a strong ethical feeling against patient-snatching. One doctor would *never* pass another on the road if he caught up to him in his buggy."

In 1881, **Charles H. Morse** walked the new railroad tracks into Eagle Grove, Iowa. He walked because he was broke and was looking for a place to practice. Today, at 96, he's Iowa's oldest active physician—and probably its most fiery-tempered. Dr Morse's uninhibited nature and his penchant for direct action have done much to improve Eagle Grove. Among other things, he once bullied the townspeople into draining their malarial swamps, and he built a hospital. Dr. Morse has also kept the town amused. According to a Chicago Tribune story, he once victimized a blackmailer who had intended to victimize *him*. The blackmailer sent his "wife" to the doctor's office to entice him into a compromising situation. Object: blackmail. Dr. Morse refused the gambit; instead, he tracked down the blackmailer, cornered him in a box car in the railroad yards, and horsewhipped him until he got a confession. Blackmailer and "wife" hurriedly left town.

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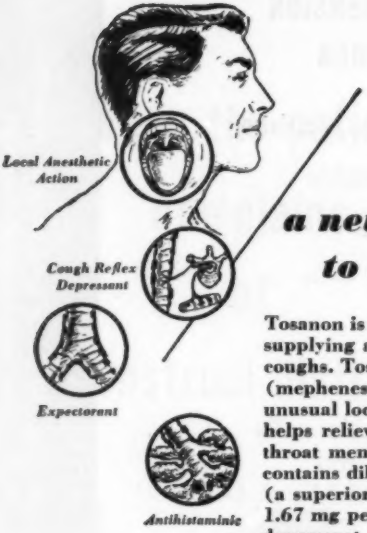

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T.M.—Tosanon

he couldn't see to read, we fitted him with glasses."

It was an era, moreover, of limited therapy. Galenic remedies were going out; most modern remedies hadn't yet come in. According to Dr. Menninger, "There was no preventive medicine except a vaccine or two, sulphur and molasses, sassafras tea, and asafoetida bags. Our drugs were largely quinine, morphine, digitalis, calomel, and salts. Doctors believed in purging and sweating but had stopped bloodletting." (Not quite *all* of them had stopped. In most cases, recalls a 92-year-old Texas practitioner, "We'd bleed 'em and give 'em calomel and quinine.")

The Lonely Years

In a day of few consultations and fewer referrals, the doctor usually worked by himself, and the memory isn't always altogether pleasant. Dr. Menninger, for example, says, "Many a time in the middle of the night, when the family looked to me as the final authority who held life and death in my hands, the responsibility and the loneliness of my work seemed almost too much to bear."

Thus for some doctors like 91-year-old Robert C. Paul, of Wooster, Ohio, "the contacts with good hospitals and the friendship of fellow practitioners" rank high among the benefits that doctors have won since those days.

Many another oldtimer disagrees, though. There were great advantages to professional isolation, says Dr. William L. Vroom, of Ridgewood, N.J., who is 86. He adds: "We couldn't call the ambulance for emergency hospital care or always refer cases. A doctor had to rely on his own initiative. He became more versatile than he does today."

And Dr. Elisha Jones, 92, of Hartford, Ark., says, "I guess we made some errors; yet we built up confidence in ourselves and among our patients."

Good Old Days

Did they have other advantages that the modern physician lacks? Yes, indeed. For one thing, they say, the doctor had a firmer position of honor in his community. For another, he knew his patients more intimately. Patients, in turn, were more loyal to him, less exacting, more appreciative of his services. Says 89-year-old Dr. Jerome S. Kendig, of Salunga, Pa.:

"These days a doctor's fee is too large for patients to want to consult him for all the little ailments. In the early days, he was asked not only to render small professional services, but often to give advice about financial, spiritual, and everyday family problems."

But no veteran denies that there's a lot to be said for medical practice in 1952. High on almost any oldtimer's list of welcome improvements are the doctor's new tools.

Yet conservative voices recommend caution. One nonagenarian, for example, says that "the new drugs kill infection quickly but recovery is

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VITAMIN A C D DROPS

supplies all the vitamins needed in the first months of life —A, C and D—in an aqueous vehicle. Contains only synthetic vitamin components—an excellent dietary supplement for those who cannot tolerate natural source vitamins.

Contains (per 0.6 cc): 5000 U.S.P. units Vitamins A—1000 U.S.P. units Vitamin D_3—50 mg. Ascorbic acid

Bottles of 15 and 50 cc. with calibrated droppers.

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provides balanced amounts of the vitamins necessary to proper nutrition in normal infants, in a stable, water-miscible solution. Contains only synthetic vitamin components. Unusually pleasant tasting when taken directly; does not alter the flavor of foods with which it is mixed.

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1 mg. Thiamine hydrochloride U.S.P.—0.4 mg. Riboflavin
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Bottles of 10, 30 and 50 cc.

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slower." A second complains that the average young doctor "is too anxious to use antibiotics in every case he sees. He forgets that nature, if not interfered with, will do a lot for the patient."

Cars Are Helpful

Actually, some of the less spectacular changes impress older practitioners more than do innovations in medical science. They often emphasize, for example, how the path of the doctor on his rounds has been smoothed by good roads, bridges, and cars. They point out also how much better trained today's office and hospital assistants are. And of course they're pleased at the physician's increased earning power.

Many of them have rueful memories of the time when the doctor sent out bills only once a year—after the fall harvest. This made for easy bookkeeping, but it could also be a hazard for the unwary. Take an early experience of Cyrus K. Sharp, an 84-year-old general practitioner, of Arlington, Ga.:

Year Without Pay

Back in 1898, just out of medical school, he agreed to pinch-hit for a small-town doctor who was allegedly taking a three-month vacation. "He never came back," recalls Dr. Sharp. "I was left holding the bag, and I had to finish out a whole year in that town just to make my collections the following fall."

In another respect, too, life seems easier for the modern M.D. Though none of the older men specifically mentions it, there has obviously been a remarkable change for the better in our weather. Climatologists, if they study the annals of medical practice, will be astonished to learn that there was hardly ever a sunny, dry day or a balmy, starlit night half a century ago. Like the wars of old soldiers, medical practice—in retrospect, at least—appears to have been conducted mostly in heat or cold, in rain, sleet, snow, or gales.

Longevity Secrets

But in spite of (or because of) the rigors of those years of rugged practice, many physicians lived to enjoy an active old age. Can they provide formulas for healthy survival? Of course they can.

Take Dr. Edmund B. Montgomery, of Quincy, Ill. His medical school teachers predicted that this delicate youth wouldn't last much beyond the age of 25. As a result, he never started to drink or smoke, and he conscientiously observed all the rules of hygiene. His reward: He's now 93, and still in active practice.

A quite different nonagenarian, waving his cigar smoke away from his face, says, "I've violated every health law I know. So how have I managed to reach 90-plus? Well, it's simple: I never have my blood pressure or urine checked, never feel my pulse, and never take a dose of medicine. I don't know if anything is the matter with me, so I never have to worry about it." END

Beware of 'Simple' Tax Errors

[CONTINUED FROM 67]

says that annuity income amounting to no more than 3 per cent of the total cost of the annuity is taxable every year; only payments in excess of this escape the levy. (After the entire principal has been repaid, *all* further payments become taxable in full.)

All the above cases may involve hundreds of dollars in taxes. But tax bloopers needn't be big to bring on the T-men.

Take the case of a G.P. in Texas. In his town, water bills are usually referred to as "water taxes." And that, in his innocence, is how he listed them in his tax return—for his home as well as his office. The Treasury men, however, pointed out that such bills aren't taxes at all, and that they're deductible only as a professional expense in connection with an office. And once they'd straightened the doctor out on *this* point, they began hunting for other possible errors.

Again, doctors have been called to account for treating as a full professional deduction the 3 per cent tax on employes' salaries. Actually, only half this tax is deductible; the remainder is the employe's contribution, which was merely withheld by the doctor.

There are several other ways of inviting a Treasury probe. For instance, you can fail to report dividends or bond interest. Or you can try to deduct for non-deductible taxes (e.g., Federal amusement taxes). Or you can simply make mistakes in your mathematics. Any one of these errors, no matter how innocent, can mean trouble.

Cheating Yourself?

But there's one kind of mistake that *doesn't* bring the revenue men running—the kind where physicians cheat only themselves by erring in the Treasury's favor and paying too much tax.

Many physicians, for example, forget to deduct the fees charged by credit agencies for collecting unpaid bills. But the fees are legitimate professional expenses.

Others miss out by failing to deduct bonuses and Christmas gifts to employes, though such payments are clearly compensation. Still other doctors buy tax-exempt securities and mistakenly lump the interest in with other taxable income.

Of course, if such errors are discovered, the taxpayer gets a refund. But *you* aren't likely to go over your return to spot mistakes, once you've filed it. And you can't expect an agent to do a lot of detective work for *your* sake.

So check those returns carefully before you kiss 'em good-by. Better still, have a tax consultant do it. One way or another, that extra bit of caution is likely to pay off. END

'Ethics Should Protect Patient, Not Doctor'

Many physicians assume that medical ethics are designed "for the protection of one doctor against the encroachments of another." But this, says Dr. John T. Hundley of Lynchburg, Va., is a false assumption.

"The principles of medical ethics . . . are designed primarily to prevent harm to the patient," he points out. And with this in mind, he urges doctors to broaden their concept of professional ethics and to show concern over such violators as these:

¶ "The general practitioner who persists in treating a condition for which he lacks training and experience . . .

¶ "The specialist who exceeds his own field and cares for problems out of his domain, or retains a patient referred to him for a particular purpose . . .

¶ "The doctor who knowingly exceeds his professional capacity, to hold a profitable insurance case or contract."

¶ The doctor who refers patients on "the basis of friendship or reciprocated favors."

¶ The fee gouger.

Adds Dr. Hundley: "The public judges the medical profession by the jackleg, the chiseler, the exorbitant charger, [and] the shady practitioner," as well as by their betters. "If we claim credit for the shining light, we must . . . take responsibility for the canker within our professional body."

One-Fifth of Families Owe Medical Bills

Ever stop to think how many patients owe money for medical care? The Federal Reserve Board has; and it found out recently from a cross-section of the nation's families that 19 per cent of them are indebted to either their doctor, hospital, or dentist.

As part of its annual Survey of Consumer Finances, the board's research staff asked people of every type about their medical debts. Most of the debts were small, it was found—about three-quarters of them amounting to less than $100.

Surprisingly, the lowest income groups were *not* proportionately the heaviest debtors. Less than 18 per cent of families earning $2,000 or under owed for medical care; but in the $2,000-$4,000 bracket the figure was 22 per cent. The board points out that the middle-income brackets probably spend heavily for

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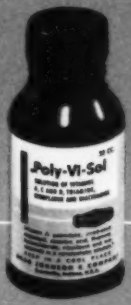
Superior flavor that assures patient acceptance . . . and superior dispersibility in formula, fruit juice or water . . . are among additional advantages provided by all three of Mead's water-soluble vitamin preparations.



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It's the taste of Mulcin that all children like . . . the refreshing flavor of real orange. It's the ready acceptance of Mulcin that all mothers appreciate . . . no more need to coax or bribe even finicky children.

The light, smooth texture of this vitamin emulsion makes pouring easy. And Mulcin needs no refrigeration; even at room temperature its potency is assured.

Each teaspoon of MULCIN supplies:

Vitamin A	3000 Units
Vitamin D	1000 Units
Ascorbic Acid	50 mg.
Thiamine	1 mg.
Riboflavin	1.2 mg.
Niacinamide	8 mg.

Available in 4 oz. and economical 16 oz. bottles.

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automobiles and expensive appliances; as a result, they have less available cash for medical expenses.

On the other hand, the amount of debt apparently varies with the occupation of the family head just about as you'd expect it to:

	No Debt	Some Debt
Self-employed	90%	10%
Professional	88	12
Managerial	84	16
Clerical & sales	81	19
Skilled & semi-skilled	77	23
Unskilled & service	79	21
Farm operator	77	23

Is There Really a Youth Movement in Medicine?

It's sometimes said that younger men are now taking over more of the leadership posts in organized medicine. But on the top level, at least, the youth movement seems to be proceeding at snail's pace.

That's the main conclusion to be drawn from a comparison of two analyses of the A.M.A. House of Delegates—one made in 1947 by this magazine, another made recently by Dr. F. F. Borzell, past speaker of the house.

In 1947, the average delegate was 60 years old; in 1952, he was 59. The difference could mean a slight trend toward younger delegates. But the average delegate is still much older than the average U.S. physician, who at last report was 44.

Though the house isn't overflowing with young blood, it's not because its members are permanently entrenched. As a matter of fact, there's a fairly rapid turnover in delegates. For example, 107 of the 1952 crop (56 per cent) had served less than five years at the time of Dr. Borzell's analysis. Only twenty-three had served more than ten years. Longest period of service: twenty-two years.

A few more G.P.'s found their way into the upper echelon during the five-year period, but their numbers were still small. Eighteen were serving in the 1952 House of Delegates, whereas there had been less than a dozen in 1947. Even today, only about 10 per cent of the delegates are G.P.'s, though G.P.'s account for about 65 per cent of the country's doctor-population.

First-Year Residencies Are Going Begging

One out of three first-year residencies now goes unfilled. What's more, there's no sign of early improvement.

Such are the findings of a recent A.M.A. survey. It discloses that of 9,340 first-year positions offered in 1951-52, only 6,376 were taken. That's just 68 per cent.

In individual fields, the percentage of filled residencies ranged from a high 90 (for cardiovascular diseases) to a low 45 (for general practice). Residents are apparently hard to find in such fields as neurology, pathology, physical medicine, and contagious diseases. In all these

How to open the new COLOR-BREAK* *ampul*

The new Color-Break Ampuls are easy and safe for you or your nurse to open.

Just hold one as you would an ordinary ampul.

Put pressure on the top as you always have with ampuls.

Snap! You've made a clean, easy break and the ampul is ready to use.

No filing
No scoring
No sawing

Just snap. And Color-Break Ampuls are ready for use.

Color-Break Ampuls are Neutraglas Ampuls. And, they are coming off the filling lines of many producers of parenteral solutions. When you get a carton of them, remember: with patented Color-Break Ampuls, just snap off the top. There is no filing, no scoring, no sawing.

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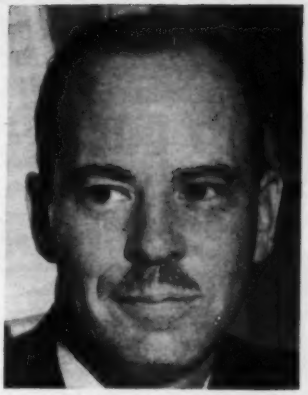
specialties, almost half the positions offered were passed up in 1951-52.

Other specialties—for example, ophthalmology, dermatology, pediatrics, proctology, and obstetrics-gynecology—did better. In these fields, at least three out of four residencies were filled.

But even so, says the A.M.A. Council on Medical Education and Hospitals, there's been a percentage drop in filled residencies in every major specialty during the past few years. And the downward trend seems likely to continue—unless there is a change in the number of applicants available as a result of the return of physicians from military service."



Edwin P. Jordan
He gets groups started

Consulting Help Offered Embryo Medical Groups

Are you thinking of organizing a medical group? If so, you may want to take advantage of a consultation service now offered by the American Association of Medical Clinics, Box 114, Charlottesville, Va.

Through a study of over sixty clinics, the association has gathered a quantity of basic information on group practice, according to its executive director, Dr. Edwin P. Jordan. It has decided to offer the consulting service instead of publishing its know-how, he says, because "plans for the organization of a group should be tailored to the particular circumstances." Fees for the service: $50 a day plus expenses, for members of the association; $100 a day plus expenses, for non-members. But, adds Dr Jordan, "we're not [yet] in a position to undertake an enormous amount of work in this advisory capacity."

Says Small-Town Medical Care Is Now Excellent

Small-town medical care has improved faster than most patients realize. So instead of rushing off to places like the Mayo Clinic, they ought to put more faith in local talent, says Dr. Don Branham.

In a recent bulletin of the Oklahoma County Medical Society, Branham calls attention to "a quiet revolution in the distribution of good medical care" in his own state. "Fine hospitals staffed by superbly trained doctors are being developed," he points out; "and as a result medical

care in small towns is not what it was twenty years ago.

"If patients will consult and have confidence in their home doctor, who has an office just around the corner, they will discover . . . one whose graduate qualification is superior to most run-of-the-mill personnel . . . in the well-advertised centers." And, incidentally, he adds, "look at all the railroad fares patients would save."

Do Laboratory Tests Waste Patients' Money?

More than 80 per cent of all lab tests are negative, says Dr. Harold T. Golden—and this means that too many doctors are wasting patients' money.

He admits that a negative test is sometimes important. But, he adds, "such a preponderance of negatives is merely a symptom of laziness in ourselves." And he feels that goodwill, as well as cash, may be lost by the "habit we have acquired of allowing our diagnosis to be made by

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each lime-colored, scored tablet combines:

MEPHENESIN 400 mg.
modern relaxant of choice • Council Accepted
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tried and true sedative • Council Accepted

Seconesin is safer because its euphoric influence is attained with a minimum of secobarbital... and because both its components are rapidly dissipated and eliminated. No fear of cumulation or "hangover."

Daytime relaxation **with Seconesin is so calming that most patients *sleep well at night* without hypnotics.**

Average dose: 1 Seconesin tablet every 4 hours; 1 or 2 on retiring but this is usually not necessary. Supplied on your Rx in bottles of 50, 100 and 500 tablets.

samples (perhaps for personal trial) **and literature on request.**

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Therapeutic Preparations for the Medical Profession

Consider the diagnosis:

Patient over 40...
extremely painful recurrent arthritis...
resistant to routine antiarthritic
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1. McCracken, J.P. et al: Gout: Still a Forgotten Disease, J.A.M.A. *131*:367-372 (June 1) 1946.
2. Freyberg, R.H.: Practical Considerations in the Management of Arthritis, Pennsylvania M. J. *51*: 729-738 (April) 1948.

GOUTY ARTHRITIS

Arthritis which occurs acutely or subacutely and is associated with complete remission "should be considered gout until proved otherwise."[1]

In early attacks especially, states Freyberg,[2] "gouty arthritis may be difficult to differentiate from other forms of acute arthritis. In such instances the therapeutic test with colchicine should be employed."

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Each Tablet Cinbisal contains:

Colchicine.....0.25 mg. (1/250 gr.)
Sodium Salicylate.....0.3 Gm. (5 gr.)
Ascorbic Acid.....15 mg.

So dramatic is the response to Cinbisal that it may well be employed as a therapeutic test in the diagnosis of gouty arthritis. Cinbisal promotes urate elimination via the kidneys and relieves pain promptly.

SUGGESTED DOSAGE:

One or two tablets every four hours.

SUPPLIED:

Bottles of 100 and 1000 tablets (Engestic ® coated green.)

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laboratory technicians trained in a few months."

In the interest of better public relations, Dr. Golden, who is president of the Herkimer County (N.Y.) medical society, recommends that doctors "sit back and take stock of the way we spend our patients' money for them, particularly in the multiplicity of . . . tests we are having performed daily."

Local Society Clarifies A.M.A. Ethics Code

A good many doctors have been embarrassed at one time or another by their failure to abide by the profession's code of ethics. But it's not always their fault. Sometimes organized medicine itself may be blamed for not having adequately defined the bounds of ethical conduct.

In an attempt to plug the loopholes, the ethics committee of the Wayne County Medical Society (Mich.) has now put some of the broad A.M.A. principles into more specific terms.

The A.M.A. code says, for example, that "solicitation of patients, directly or indirectly . . . is unethical." As interpreted by the Wayne committee for local doctors, this means that it's improper for an M.D. to:

¶ Associate with an organization that uses advertising methods to attract patients;

¶ Permit himself to be introduced in laudatory terms before lay audiences;

¶ Entertain insurance adjustors or plant officials who are responsible

M&R Pediatric Research Conferences

A continuing examination of current research in specific fields of pediatric interest

1. **Megaloblastic Anemia**
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2. **Retrolental Fibroplasia**
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4. **Calcium and Phosphorus Metabolism**
5. **Pulmonary Hyaline Membranes** *(in press)*

The purpose of the M & R Pediatric Research Conferences, as expressed in the first Conference Report, is to assist in the correlation of the latest research information on specific topics of general interest in the care of infants and children, and to stimulate further research by exchange of information. These objectives arose from the original aim of the Conferences, which was to keep the scientific staff of M & R Laboratories abreast of latest developments in pediatric research. The range of subject matter is reflected in the titles of the first five Conferences.

The first of the Conferences was held on November 16, 1950; and so enthusiastic has been the response during the past two years, in terms of participation and general interest, that M & R plans to continue its sponsorship indefinitely as a long-term program.

The Fourth Conference dealt with calcium-phosphorus metabolism and included discussions of the most recent authoritative thinking on such vital and timely subjects as: effect of dietary calcium and phosphorus in newborn infants; actions of vitamin D and related sterols; renal excretion of phosphate in newborn infants; effect of parathyroid hormone on renal phosphate excretion; effects of estrogens, androgens and administration of strontium; and effects of immobilization. The Fourth Conference Report is now available to physicians who can obtain it by writing to M & R Laboratories, Columbus 16, Ohio.

M & R Laboratories, Columbus 16, Ohio

Gentlemen: Please send me the Report of the Fourth M & R Pediatric Conference, "Calcium-Phosphorus Metabolism."

Name_____M.D.
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Practice — please indicate:
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for placing insurance contracts (or, as a matter of fact, do anything that implies an invitation to such persons to send him patients);

¶ Allow his name (1) to be circulated among members of a church, lodge, or similar organization, even if he is a member himself; (2) to be listed on a professional directory in a store; (3) to be printed on table covers, balloons, bowling shirts, or church calendars.

The committee also lays down rules about physicians' signs. They must, for example, conform "with the architecture of the building, the nature of the neighborhood, and the dignity of the profession." Size is limited to four feet by two feet, with letters no more than four inches high. Neon signs are permitted only if one color is used and if they don't flash off and on.

In addition to laying down the law, the committee offers doctors specific advice on kindred subjects. For example: [MORE→

Anecdotes

¶ MEDICAL ECONOMICS will pay $10-$25 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

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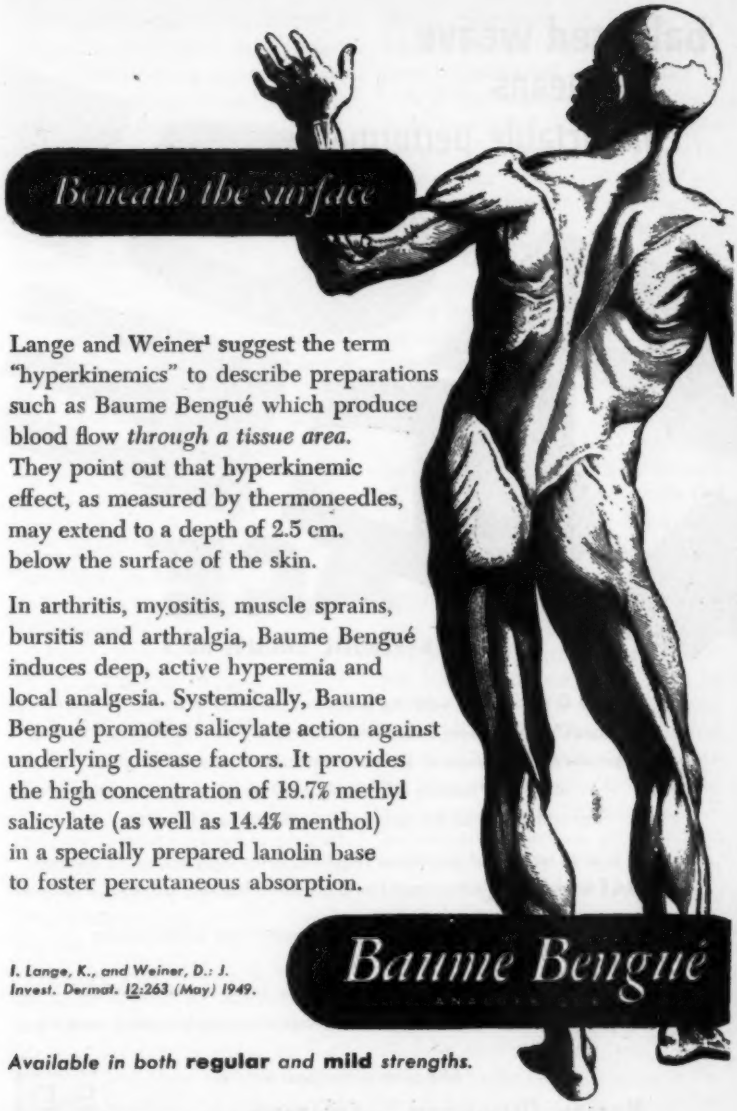


Lange and Weiner[1] suggest the term "hyperkinemics" to describe preparations such as Baume Bengué which produce blood flow *through a tissue area.* They point out that hyperkinemic effect, as measured by thermoneedles, may extend to a depth of 2.5 cm. below the surface of the skin.

In arthritis, myositis, muscle sprains, bursitis and arthralgia, Baume Bengué induces deep, active hyperemia and local analgesia. Systemically, Baume Bengué promotes salicylate action against underlying disease factors. It provides the high concentration of 19.7% methyl salicylate (as well as 14.4% menthol) in a specially prepared lanolin base to foster percutaneous absorption.

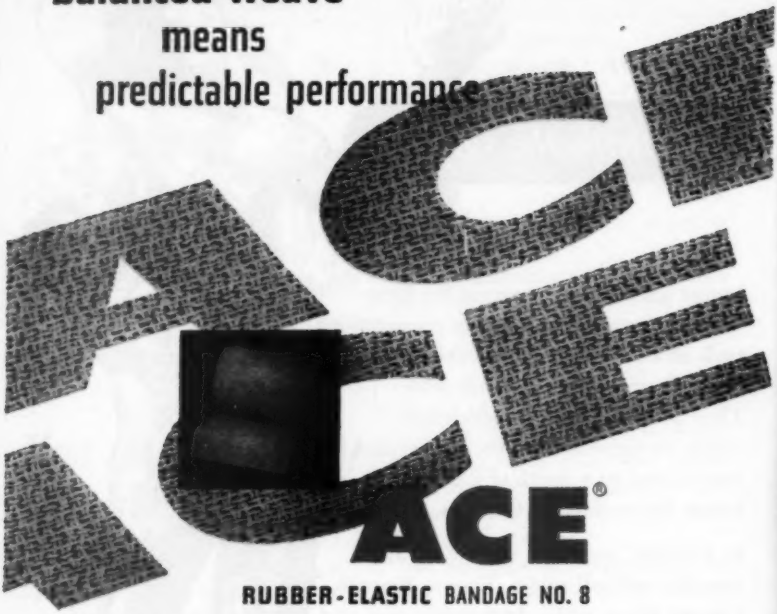
Baume Bengué

1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

Available in both **regular** *and* **mild** *strengths.*

Thos. Leeming & Co. Inc. 155 East 44th Street, New York 17, N.Y.

balanced weave
means
predictable performance



RUBBER-ELASTIC BANDAGE NO. 8

B-D research in weaving processes assures the proper proportion of best quality, long staple cotton and latex yarn. This "balance-in-weaving" produces a bandage of uniform stretch and body. When you apply the famous **ACE** Rubber-Elastic Bandage, you know it will provide optimal therapeutic benefits for your patients.

In a wide variety of conditions requiring extra compression or support, **ACE** Rubber-Elastic Bandage No. 8 provides these exclusive **ACE** features:

balanced weave provides optimal support with uniform tension throughout the afflicted area

built-in elasticity minimizes slipping or loosening of the bandage

exclusive weave and skin-tone shade assure comfort and acceptability

ACE Bandages Are Made ONLY By

BECTON, DICKINSON AND COMPANY RUTHERFORD, N. J. B-D

B-D and ACE T.M. Reg. U.S. Pat. Off.

On consultations. It's better to suggest a consultation than to wait for a patient to request one. In any event, the patient should be given a choice of consultants. It's also wise to tell him that each physician will submit his own bill.

On being frank with patients. The patient or his family is entitled to a warning about a possibly fatal outcome if (1) he may wish to consult his pastor; (2) he may have a will or other legal matters to consider; or (3) he has specifically requested such a warning.

On avoiding possible suspicion about kickbacks. If the patient asks the doctor to recommend a druggist, dentist, or lawyer, it's best to give him more than one name. Also, the M.D. should avoid using prescription blanks that bear the name of a pharmacy, optical company, or similar concern.

How to Save Taxes on U.S. Savings Bonds

Most doctors—like most other people—accumulated a stack of series E savings bonds during the last war; and now these investments are starting to mature. But before you rush to cash yours in, the U.S. News & World Report suggests you consider this point:

You may now hold a war bond for ten years beyond its maturity date, and your interest income "need not be reported for tax purposes until the bond is cashed in. The interest on the bond, while it is held, accumulates, increasing the bond's face value . . . at the rate of 3 per cent a year, compounded semiannually."

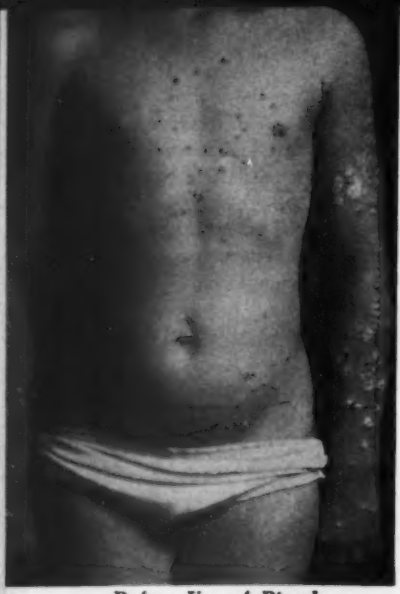
So if you wait until 1963 to cash in the bond you bought in 1943, you can put off paying taxes on your investment for another ten years. And, according to the magazine, "barring big war," taxes will be cut in the future. Thus, you'll be making a substantial saving on your tax bill.

But even on the basis of present tax rates, there's a possible advantage in waiting, the magazine asserts. It cites the following hypothetical case:

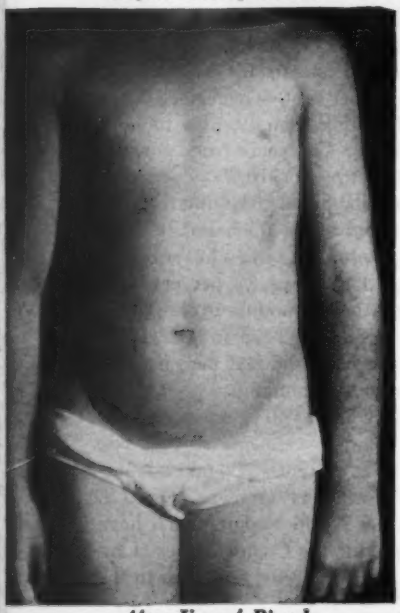
Take two men, each 55 years old, each married, each with an income of $25,000 a year, and each the holder of a $1,000 war bond now coming due. The first man cashes it in now and pays income tax on the $250 interest. In his bracket, he pays 42 per cent—which is $105.

The other man decides to hold the bond. Ten years from now, at 65, he retires on $10,000 a year and cashes the bond. The interest has now reached $596.80; but because the investor is now in a lower bracket, his tax is just 22 per cent. So his payment amounts to $131.30—which, the magazine stresses, is little more than the first man paid on a far smaller amount.

But what if you've arranged your war bond investments so that you pay taxes currently? To take advantage of the tax savings, says U.S. News & World Report, you'll have to apply to the Commissioner of Internal Revenue for a change to the



Before Use of Riasol



After Use of Riasol

COLD FACTS on RIASOL in Psoriasis

Cold weather aggravates the itching and eruptions of psoriasis. To keep the disease under control, many physicians prescribe RIASOL.

Psoriasis is the 8th most common skin disease, 6% of all cases. Treatment in a series of 231 cases with various drugs other than RIASOL produced remissions in only 16½% cases.

RIASOL showed clinical improvement in 76% cases of psoriasis. It proved satisfactory in neglected cases. The skin lesions cleared up in an average of 7.6 weeks, in 8 typical cases treated with RIASOL.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

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Please send me professional literature and generous clinical package of RIASOL.

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RIASOL FOR PSORIASIS

deferred status. But the magazine thinks such permission "may well be granted."

The Television Doctor May Be Here to Stay

Have you met the television doctor? He's that man in impeccable white who prescribes cigarettes, mouthwash, and laxatives to millions—unaided by medical training. You may not relish him as a colleague, but he's going to be around for a long time.

MEDICAL ECONOMICS has made a check of Government agencies and private organizations that could conceivably have some jurisdiction over the ethics and practices of TV advertising. And it appears that no such agency has either the authority or the staff to police the airwaves.

Take the Federal Communications Commission, for example. Its job is to regulate broadcasting in the public interest. It guards against signal interference; it insists on public welfare programs; it tries to insure expression of all points of view. But the law specifically forbids the commission to censor programs.

The National Association of Radio and TV Broadcasters—the industry's own trade group—is also powerless to interfere. It has a code of good practice; but there's nothing in the code to prevent an announcer from putting on a white coat and playing "doctor." To be sure, the code says something about "good taste" and calls for action when there's reason to believe that broadcast statements are untrue. But the play-acting man in white is evidently not considered cause for action.

There is, of course, one agency that can police food, drug, and cosmetic advertising: the Federal Trade Commission. It has authority to act against misleading advertisers on its own initiative or on complaints from the public. If necessary, it can even go to the courts to halt harmful and misleading practices.

But the F.T.C. has received no complaints against TV "doctors." It has considered starting action on its own, but its staff is limited. Besides, there are scores of other situations that the commission considers more urgent.

There's one ray of hope, though. F.T.C. officials say privately that the matter doesn't have to die. If the medical profession should ever launch a sustained protest, the commission would be *forced* to act.

Society-Page Publicity Called Bad for M.D.'s

You've seen those chatty little items in the social notes about doctors and their families. Well, they're bad public relations, warns Dr. Herman Harding of Liverpool, N.Y.

Why? Because they often amount to public evidence of prosperity and may well antagonize patients who belong to a "less fortunate social group." In addition, says Harding, frequent social notes about a doctor's comings and goings (or about

his wife's tea parties) are perilously close to unethical publicity.

"Spread on the minutes of [our county medical society] are many prohibitions against members getting into print unduly," Harding points out. "Yet, what happens? If some medical group in Ethiopia . . . asks one of our brethren to come there to speak, we get a heap of publicity about his specialty, with all the details except office fees."

Many Meetings Too Dull, Say Stay-Away Doctors

Why do many doctors stay away from medical meetings? The answer is simple: For the most part, the meetings aren't interesting enough.

That's the basic reaction of some 700 physicians to a questionnaire sent them by Dr. Floyd S. Winslow and the public relations committee of the New York State medical society. More specifically, they complain that:

¶ Meetings don't begin on time, run too late, and last too long.

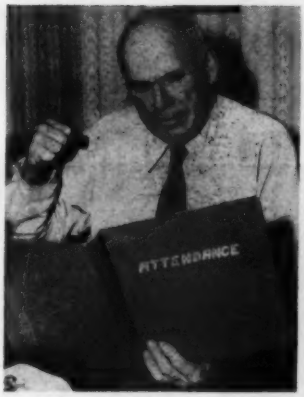
¶ Cliques tend to control many county societies and their meetings.

¶ The gatherings are too stiff; there's no fellowship.

¶ Papers are poor and poorly presented.

¶ Routine business eats up too much time; there's too much argument and needless discussion.

Through most of these and other complaints runs a thread of criticism of the presiding officers and the administrative practices of county societies. But there are simple solutions to several of the problems, say many of the surveyed doctors.



Floyd S. Winslow
Bait for the reluctant

For example, some of them suggest that lengthy floor discussions can be avoided by inviting each member to present his views to the appropriate committee. And others recommend rotation of committee membership, with sufficient overlapping to insure continuity.

One interesting finding of the New York survey: There appear to be wide differences between rural and urban doctors in their approach to the problem. For example:

¶ Where a *regular* meeting place may be convenient for physicians in a city, doctors in rural counties prefer frequent changes of locale.

¶ Transportation is no special problem in a city. But several country doctors suggest that younger

"Appestat Malfunction" is newest term for cause of Bulimia (*Hyperorexia*)

Development of atheromatous plaques is invariably accelerated in obese patients. These scarred aortas are from patients who succumbed (lower) at age 54, height 5'6", weight 210 lbs., and (upper) age 44, height 5' 5", weight 230 lbs.

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TABLETS PHENYLPROPANOLAMINE HCl, THYROID AND VINBARBITAL

Since errors in excess of 25% will occur in estimating daily calorie expenditure if B.M.R. is not known, determination of a safe and effective reducing diet remains the physician's responsibility.

SHARP & DOHME, Philadelphia 1, Pa.

Exercise is of little help. To burn up a single pound of excess fat it would probably be necessary to walk at least from Philadelphia to Trenton[2]—and possibly all the way to New York.[3]

doctors might form motor pools to drive older men to and from the meetings.

¶ Evening meetings are favored by city medical men; country doctors seem to prefer afternoon sessions.

¶ Urban men complain of too many meetings; country men, of too few.

The report of the New York State medical society concludes: "The results of this questionnaire served once again to emphasize the . . . indifference of many members of the medical profession to constructive, cooperative effort to improve the position of the county medical society as a force in the community." And it warns: "To other groups and the man on the street, the county society speaks for the doctor. If it is disorganized and inefficient, its voice will be weak and ineffective."

Are You Up on the Latest Medical Misinformation?

You don't know what you're missing if you learn about medical progress only from the scientific journals. But your patient is likely to know; and—bubbling with sprightly misinformation imbibed from the popular magazines—he may be amazed at your ignorance.

Do you know, for instance, "that horse-radish stimulates the bile flow and shortens the duration of infectious hepatitis . . . [or] that window-shopping will divert the fatty from eating?" asks Dr. W. S. Reveno, in the Detroit Medical News. By fol-

lowing the popular periodicals of one recent month, he reports, you might have learned, along with your patients, "about a new C-bomb that halts cancer;" about curing their constipation without drugs; and even about "how to detect dope addiction in the newborn."

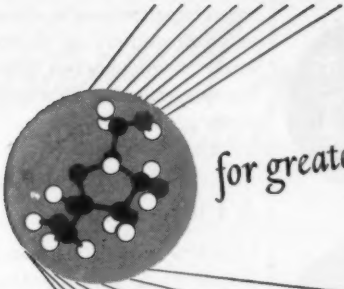
What should you do, then, when a patient comes in "with a self-made diagnosis . . . from his favorite magazine" and demands the latest treatment as described? Says Reveno, with tongue only partly in cheek: "Better broaden your reading habits or you'll find yourself stumped and embarrassed."

Is Surgeon Liable For Anesthetic Blast?

A New York man died recently as the result of an anesthetic explosion. His widow sued both the hospital and the surgeon. The court's decision: The hospital alone was responsible.

But must the hospital *always* accept full liability for such an explosion? Not necessarily, says Roy Hudenburg, secretary of the Council on Hospital Planning and Plant Operation of the American Hospital Association.

Writing in the magazine Trustee, he points out that the National Fire Protection Association has recommended a series of safety measures designed to eliminate sources of danger from operating rooms. Once the hospital has taken such precautions, he suggests, it can then "require the surgeon to take the responsibility



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(INVERT SUGAR)

twice the calories of 5% Dextrose
in equal infusion time
with no increase in fluid volume or vein damage

With *10% Travert* solutions, a patient's carbohydrate needs can be more nearly satisfied.

Travert solutions are sterile, crystal clear, colorless, non-pyrogenic and non-antigenic. They are prepared by the hydrolysis of cane sugar and are composed of equal parts of D-glucose (dextrose) and D-fructose (levulose).

Nine *Travert* solutions enable the physician to correct electrolyte imbalances, acidosis and alkalosis, as well as supply twice the calories of 5% dextrose.

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GENERAL OFFICES • EVANSTON, ILLINOIS

when he introduces an element such as electrocautery or electrosurgery in the same operation for which he has prescribed a flammable anesthetic agent."

How Specialized Can A Physician Get?

Creation by the American Board of Pediatrics of a new subspecialty—"pediatric cardiology"—has drawn a sharp protest from the Norfolk Medical News. Will the trend toward over-specialization continue, it wonders, until "freckle specialists" dot the medical scene?

Does certification of pediatric cardiologists imply that such specialists must limit themselves to heart disease in children? asks the News. If so, "Where is the dividing line between heart disease in children and heart disease in adolescents?"

Pointing out that already complex medical problems are being further complicated by the creation of more and more specialties, it warns against the "house of cards built by the specialty boards." It concludes that the profession may yet see the collapse of "this frail structure" unless the A.M.A. steps in to take control.

Do Doctors Have a Right To Talk Politics?

Must a banker speak of nothing but banking? Must a lawyer be silent until the conversation gets around to law? Must a barber stick to the scalp—and a doctor to the scalpel?

Certainly not, asserts Dr. Glen

Outstanding among Tar Preparations

- FOR CLINICAL EFFICACY
- FOR FREEDOM FROM REACTIONS
- FOR COSMETIC ELEGANCE

Tarbonis combines the three features needed for successful management of a host of dermatologic conditions:

It presents *all the therapeutic properties* of crude tar, but in a form liberated from the undesirable properties which so long have made tar therapy unacceptable to physician as well as patient.

It is so nonirritant, in spite of its dependable efficacy, that it is safely used for infants and on the tenderest body areas.

Tarbonis presents a specially processed liquor carbonis detergens (5 per cent), together with lanolin and menthol, in a vanishing-type cream base. It is greaseless, free from all tarry odor, and—since it leaves virtually no trace on proper application—is appreciated by the patient, especially when exposed body surfaces are involved.

TARBONIS is available through all pharmacies upon prescription. For dispensing purposes TARBONIS is packaged in 1-lb. and 6-lb. jars through Physicians' and Hospital Supply Houses.

In ECZEMA
INFANTILE ECZEMA
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Physicians are invited to send for clinical test samples to demonstrate the antipruritic, decongestant, remedial properties of Tarbonis in the conditions listed above.

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You may send me a sample of Tarbonis.

_____ M.D.

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ME1

Shepherd, in his syndicated column.

"Only a generation or two ago," he goes on, "doctors had a respected place in the village council . . . But now, some folks feel that when a physician speaks out on economics or sociology or the body politic, he is not sticking to his last—he is talking about matters on which he certainly has no special information."

It's "a pernicious idea," Dr. Shepherd maintains. As informed citizens, he adds, physicians have a perfect right to interest themselves "in taxes, prevention of wars, and other civic or political matters."

Citizenship, in short, "is everyone's business," concludes the columnist. "When we shut out each other's views because this man represents labor's special interests or that man represents medicine's supposed vested interests (neither of which really exists), then we are defaulting our citizenship birthright."

Business Sparks Campaign For New Hospitals

Is big business really willing to help support good medical facilities? The recent experience of one community provides an excellent answer to the question. In the four years since the Greater Detroit Hospital Fund was organized, Detroit corporations have consistently set the pace in a record-breaking $20 million drive for new hospitals.

According to James B. Webber Jr., president of the fund, business did more than just sign checks. Writ-

specifically indicated in biliary constipation

Constipation is usually associated with biliary stasis and impaired digestion. Tablets of Caroid and Bile Salts with Phenolphthalein offer 3-way help in the reestablishment of normal function in these cases.

CHOLERETIC ACTION
- Stimulating bile flow for easier fat digestion

DIGESTANT ACTION
- The enzyme, "Caroid," promotes protein digestion

LAXATIVE ACTION
- With minimal laxative dosage

Supplied: bottles of 20, 50, 100, 500, and 1,000.

Write for a trial supply today!

American Ferment Co., Inc.
1450 Broadway, New York 18, N. Y.

Caroid® and Bile Salts TABLETS

specifically indicated in biliary dyspepsia and constipation

ing in Hospitals magazine, he points out that local corporations provided the first impetus for a 1947 survey of hospital needs. And then business executives followed through by contributing leadership to the management of the campaign.

Of the $20 million raised, Webber adds, more than 60 per cent came directly from corporations, on the basis of a formula calling for contributions of $27.91 per employe. Such industrial giants as Ford, General Motors, and Chrysler applied this formula and wrote checks ranging up to almost $2.5 million, as in the case of Ford. Over and above this contribution, the Ford Foundation handed over a gift of $1.5 million.

The result of such widespread corporate interest: "Three major hospitals are nearing completion—one is partially open to patients. Nine additions to existing hospitals are fast adding beds in a race with the dangerous overcrowding which has steadily grown worse since the last war." A fourth new hospital is soon to be constructed, along with a tenth addition.

Total number of new beds: 1,800. And, says Webber, "it was the corporations and their top executives who put the movement over."

Law Favoring Doctors Leaves 'Em Cold

How do laws affecting doctors happen to get enacted? Here's an illustrative case in which "happen" is the right word: [MORE→

Jenny doesn't live here any more!

YES, in the modern coal mine there's no room for Jenny. Today, powerful electric locomotives pull 50 times the load that Jenny hauled to the mine surface.

And in today's mine, even the traditional pick and shovel are out-of-place! More than 90% of *bituminous* coal is now mechanically cut, over 70% is mechanically loaded. Result: more economical coal to light the way, fuel the fires, power the progress of America.

But, basically, what caused Jenny to disappear? What's behind American industry's ever-more efficient machines that turn out goods at lower cost—thus making them available to more people? One word tells the story—COMPETITION.

In the coal industry 5,000 privately managed coal companies compete with one another. When one company develops more efficient methods, the rest can keep pace only by striving to improve even further. No wonder that, with his modern machines, the American miner's daily output is 4 to 24 times that of any miner in Europe or Asia—most of whom work in government-controlled coal industries.

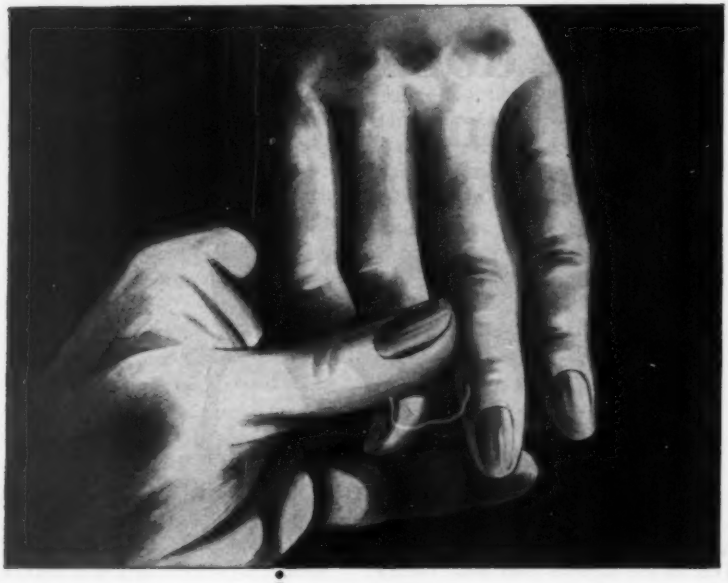
Just as competition spurs *you* on to trying harder—competition goads the individual company to deliver products that will outsell. And competition keeps a whole industry on its toes, cutting distribution costs, opening new outlets, delivering better products.

Competition—not government control—has already made America the most productive nation on earth. Competition—not regimentation—points the way to ever greater plenty for all of us.

★ ★ ★

This report on PROGRESS-FOR-PEOPLE is published by this magazine in cooperation with National Business Publications, Inc., as a public service.

THE COMPETITIVE SYSTEM DELIVERS THE MOST TO THE GREATEST NUMBER OF PEOPLE



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- **NOT FLEETING**

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ERTRON® was the first steroid complex advocated for use in the treatment of rheumatoid arthritis.

Despite the furore caused by the introduction of certain so-called 'miracle drugs' ERTRON still persists as a reliable standby in the practices of a large number of physicians.

With ERTRON, the systemic relief and objective improvement obtained is prolonged—continuous—not fleeting as is the case with some of the more recently described steroids and steroid stimulants.

ERTRON used by the physician affords a minimum of reaction. There is no observed interference with adrenal activity.

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Chicago 11, Illinois

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When Ohio decided recently to give its doctors special auto license tags bearing the designation "Physician," non-Ohioans doubtless viewed the decision as one more fruit of the doctors' legislative labors. Probably, they thought, alert leaders of the state medical society had worked hard to get this new convenience for M.D.'s.

The non-Ohioans couldn't have been more mistaken.

"As a matter of fact," says a spokesman for the Ohio State Medical Association, "we didn't sponsor the legislation and we're not enthusiastic about it. Many physicians don't want special license tags. Some say it encourages narcotic addicts to break into their cars. Others maintain that special plates attract unnecessary attention to the doctor's car."

How, then, did the state's lawmakers happen to surprise their medical constituents with the unwanted favor? It came about this way:

1. Somebody thought amateur radio operators should have special license plates for recognition in case of civil disasters. A bill to provide them was introduced in the state senate.

2. Noting that this opened up sections of the law regarding special license plates, a wide-awake senator decided that it might be a good thing if physicians, as well as "hams," were tagged. Without consulting the doctors, he offered an amendment embodying his idea.

3. The amended bill was passed.

"Obviously," says the state society spokesman, "we weren't in a position to oppose the amendment. But at the same time, we gave it no support. I think there will be some ad-

ministrative headaches connected with the bill; but of course that's no skin off our teeth. *We* didn't ask for it."

'Must You Specify Brand Names?' Moan Druggists

It's always open season on pharmacists; and the doctor's most frequent charge against them is probably that druggists "edit" prescriptions by substituting other brand-name items for the ones actually prescribed. In fact, a 1951 survey by Smith, Kline & French Laboratories indicated that such substitutions occurred 12 per cent of the time.

But there's a reverse side to this coin. It's revealed in an "off-the-record" survey of pharmacists recently made by the New York World-Telegram and Sun. Here, according to the newspaper, is the druggists' lament:

Physicians, they say, play favorites in their choice of prescription ingredients; where one doctor chooses the product of House A, another prefers the product of House B, and so on. But, complain the druggists, these products may be identical—except for the brand name.

Because identical remedies are prescribed under different brand names, the pharmacists must stock each doctor's favorite. Says one of them: "Multiply that one doctor by a dozen others favoring some other manufacturer's title for the same drug. Then you see what the druggist must keep in his prescription

When planning the diet of the OB patient, it is extremely difficult to provide for her greatly increased vitamin-mineral-trace element requirements without at the same time supplying an excess of calories.

OBRON is specifically designed to meet these greatly increased nutritional needs during pregnancy and through lactation.

for the OB patient
all in one capsule

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Dicalcium Phos. Anhydrous*	768 mg.
Ferrous Sulfate U.S.P.	64.8 mg.
Vitamin A	5,000 U.S.P. Units
Vitamin D	400 U.S.P. Units
Thiamine Hydrochloride	2 mg.
Riboflavin	2 mg.
Pyridoxine Hydrochloride	0.5 mg.
Ascorbic Acid	37.5 mg.
Niacinamide	20.0 mg.
Calcium Pantothenate	3.0 mg.
Cobalt	0.033 mg.
Copper	0.33 mg.
Iodine	0.05 mg.
Manganese	0.33 mg.
Magnesium	1.0 mg.
Molybdenum	0.07 mg.
Potassium	1.7 mg.
Zinc	0.4 mg.

*Equivalent to 15 gr. Dicalcium Phosphate Dihydrate.

J. B. ROERIG AND COMPANY • 536 LAKE SHORE DR., CHICAGO 11, ILLINOIS

department to meet the demand."

Another of the surveyed druggists said: "Why do physicians play one manufacturer against the other by writing a prescription for sulfa, penicillin, vitamin, or antibiotic, and then specifying the manufacturer at the bottom of the prescription? Very often the druggist is out of a so-called new formula. Yet he has the exact formula in stock under a dozen other names. But he must telephone the doctor and request the right to use another manufacturer's brand, although it's the same medicine."

The same man admits that many physicians willingly accept identical substitutions. But others, less cooperative, "tell us to get the wholesaler who handles the brand [they want]. This keeps the patient waiting, not to speak of the service charge tacked onto the prescription when it finally is delivered!"

Summing up the case for the druggists, the World-Telegram and Sun adds: "Ethically the physician has done nothing wrong by specifying the product of an approved pharmaceutical house. But, asks the pharmacist, why are physicians encouraging so much competition at the expense of the patient?"

Doctors Draft Themselves For Emergency-Call Duty

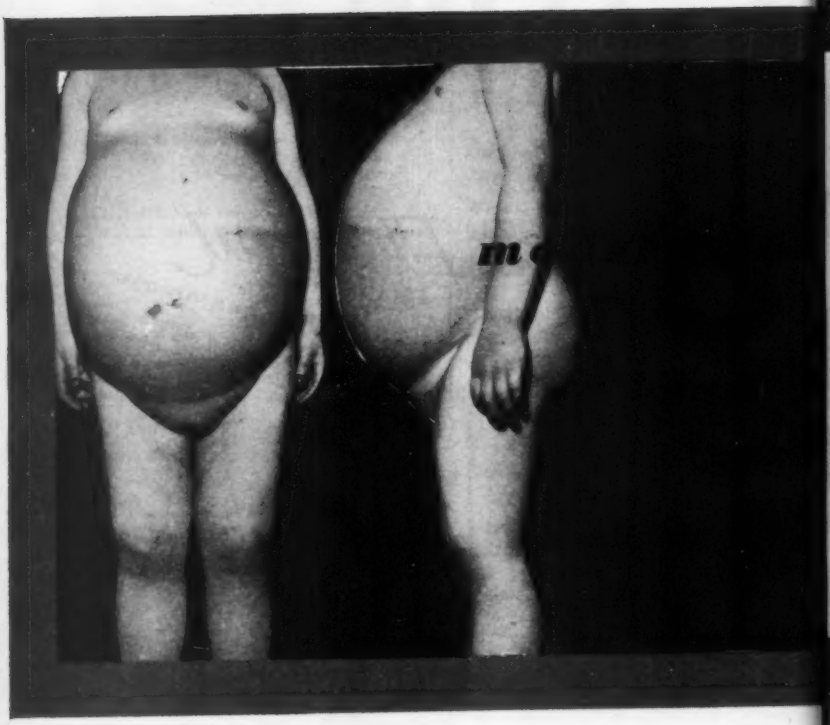
Another emergency-call plan has had its face lifted. After a short-lived experiment with a voluntary set-up, Montgomery, Md., doctors have decided to reorganize their emergen-

CAMEL

Mild, Flavorful

Pack after pack!

AMERICA'S MOST POPULAR CIGARETTE



cy call bureau on a compulsory-service basis.

The reason for the changeover may be surmised from the brief history of the voluntary system. Launched with considerable fanfare last July, it got some unfavorable publicity a few weeks later when an infant girl choked to death before a doctor could reach her. Police blamed the emergency-call bureau for the delay.

The bureau protested that the police themselves were at fault; but the county medical society soon decided that, whatever the facts, their plan needed revising. Accordingly, it voted to compel all members—specialists included—to take turns on the emergency panel.

As matters now stand, a member can expect to be tapped for twenty-four-hour emergency duty once every three to six weeks.

Doctors' Aides Organize—For Training Courses

All over the country, doctors' aides are organizing. But unlike many other workers, they're not agitating en masse for higher pay. Instead, they're banding together for courses in self improvement that will make them worth more to their employers.

Take Los Angeles as a case in point. Its Medical Assistants' Association now sponsors a double-barreled training program for aides. With the cooperation of the Los Angeles school system's Adult Division, doctors' aides now are offered special two-hour night classes once a week. And the association also

another success story WRITTEN BY THE NATION'S DOCTORS

Since 1934, our infant mortality rate has been cut by about one-half. This remarkable record is due, mainly, to widespread use of chemotherapy, increased use of immunization, greater utilization of hospitals for confinement and illness, extended prenatal programs, improved infant feeding and care.

A principal factor in this record of achievement is the unique cooperation in America between medicine and industry. Here we can truly work together, do and share scientific research, and apply the findings of research to the expansion and improvement of medical practice.

It is the exploitation of this opportunity to work with you that has made possible the highest standards of health in the world.

It is this kind of cooperation that has caused more and more physicians to favor Pet Evaporated Milk. You know, of course, that Pet Milk is good milk for babies. But just as important, Pet Milk Company stands for and aids the kind of research and service that make this a better place to live.

FAVORED FORM OF MILK FOR INFANT FORMULA

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holds monthly meetings, at which, according to an announcement of this year's activities, "well-qualified speakers . . . aid in even more extensive education."

The weekly classes, held in city high schools, consist of courses in office management, credit and collections, insurance, and medical shorthand and terminology. Qualified instructors bring the aides up to date, for example, on the latest wrinkles in taxation and accounting, Blue Shield procedure, and so on. Several Los Angeles physicians act as advisers for the entire program.

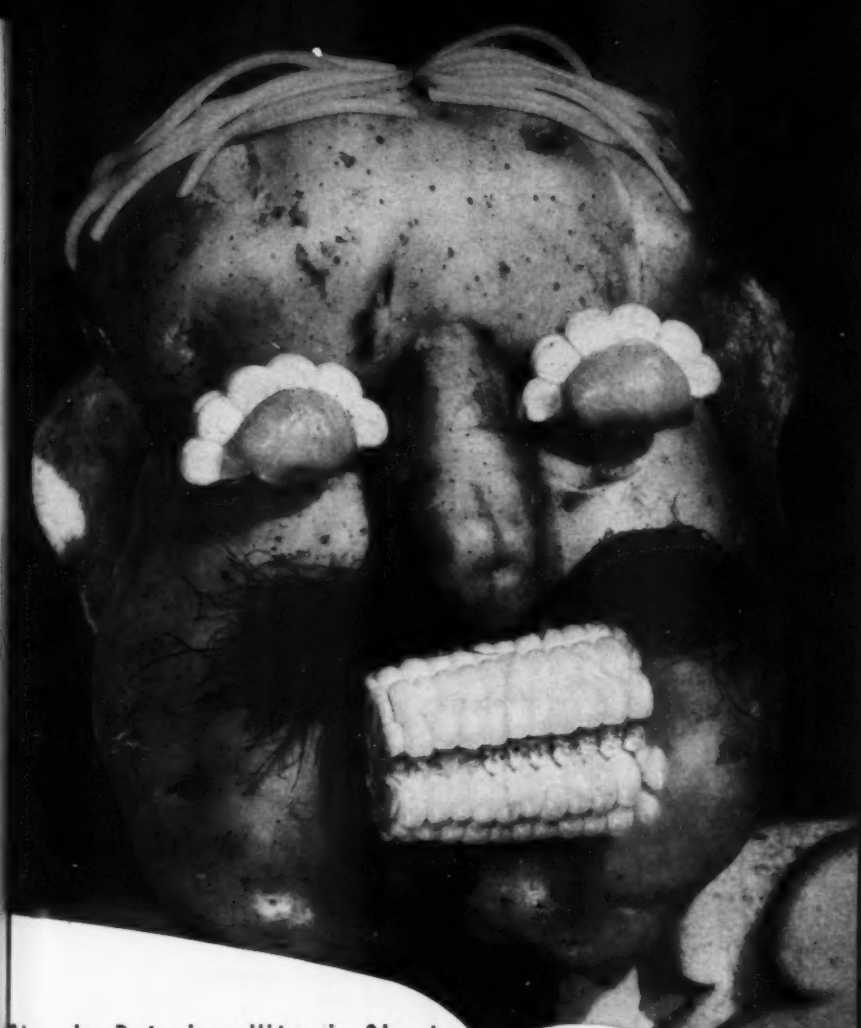
Medical Schools Warned Against 'Give-aways'

Medical schools are digging themselves into a financial hole by attempting to do too much in return for too little, says the Journal of Medical Education. They're guilty, it maintains, of taking part in "the nation's greatest give-away program." Thus, their income fails to keep pace with the dizzily climbing costs of medical education.

As evidence of the schools' shortsighted altruism, the journal points to these facts:

The schools give free care to the needy, thus shouldering a "great burden of unreimbursed costs." And they accept gifts for research projects without insisting that such gifts include funds for overhead expenses.

Such "economically unsound" policies can't be corrected by "pump primings with subsidies," the journal adds. Some schools, it explains,



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..... relaxation of nervousness, tenseness; relief of anxiety—through the "intermediate sedative" action of Butisol® Sodium

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urge Federal agencies to develop research projects on their campuses. But Government agencies "are voracious consumers."

So when the Government steps in, what happens? Warns the journal: The medical school may, among other things, be "depleted of employes, who will be lured by better salaries, often shorter hours . . . and better retirement allowances than the average school can afford."

What, then, should the medical schools do?

Their salvation, says the Journal of Medical Education, "is to adopt a strict policy of demanding payment for services rendered and of looking far into the mouths of their gift horses."

Cites Doctors' Stake In Tax Ceiling Plan

Current proposals to limit individual Federal income taxes to a maximum rate of 25 per cent have been branded "the millionaire's amendment" by the labor press. But, says John Alan Appleman, Chicago lawyer, physicians should seriously consider supporting such proposals—even though most M.D.'s aren't millionaires.

"It takes no millionaire today to reach tax brackets of 30, 45, or even 60 per cent," Appleman points out. For example, the top tax rate for a doctor with a $14,000-a-year net income is an even 50 per cent, except as split-income or head-of-household provisions may modify it. A physician earning $50,000 a year pays a top rate of 74 per cent; and a $100,000 income puts the M.D. in the 87 per cent bracket.

Such rates, he believes, discriminate against all professions—and especially against medical men, whose earning power matures only after years of training and experience.

"This is a far cry from the situation which was contemplated when [in 1913] the income tax was first brought into being," he adds. Cordell Hull, drafting the first law, favored a flat 1 per cent rate; the final formula was a graduated scale soaring to 6 per cent on incomes of more than $500,000. Governor Charles Evans Hughes of New York, fighting ratification, warned that "the Federal tax rate might get as high as 10 per cent."

Sixteen state legislatures have now gone on record as favoring a 25 per cent Federal ceiling, says Appleman. Six others took similar action, "but have, apparently, retreated under the pressure of Federal groups." In eight additional states, resolutions favoring the limitation have been approved by one branch of the legislature. And Representative Chauncey W. Reed (R., Ill.) has sponsored a tax limitation bill that may soon come up for serious consideration by the new U.S. Congress.

Is there any hope for its passage? John Appleman makes no predictions. But he points out that the 25 per cent ceiling has strong supporters—among them, the American Bar Association. Proponents of the idea

believe it would stimulate tax collections, he adds; and this would more than compensate for the amount —probably less than 2 per cent—it would slice from Federal revenues.

First British Health Center Finally Opens

A few years ago, British medical planners were envisioning 2,000 new health centers as the keystone of the National Health Service. Fruit of that vision to date: one medical center—with space for eight physicians—which has just been opened in Bristol.

A few others are being constructed. But most of the project remains in blueprints, bogged down by a lack of money and building facilities.

Even Health Minister Iain Macleod is uncertain about the direction the health center program should now take. As originally pictured, these centers were to bring general men and specialists together under one roof. "Every modern device required for non-hospital practice" was to be placed at their disposal. But now, says Macleod, he wants to watch the Bristol center closely before pushing the whole project much further. In his speech at the opening, he posed several questions that he hopes the new health center may answer:

¶ What type of center will provide the best all-around service?

¶ Can such a center provide an appropriate background for general practice?

Iain Macleod
A 2,000-to-1 compromise

¶ Will general practitioners actually benefit from working alongside their colleagues?

Pending answers to these questions, Macleod believes "it would be foolish to encourage authorities to build large numbers of health centers."

Fee Booklet Stimulates Flood of M.D. Queries

Doctors are showing unprecedented interest in standardized fees, says Dr. Paul D. Foster. And he ought to know. In the first weeks after a MEDICAL ECONOMICS article described his fee-schedule booklet for patients, letters from nearly 800 physicians in forty-six states poured into Fos-

ter's Los Angeles office. The writers wanted copies of the booklet; but many of them also asked the question: "Can a standardized fee schedule really work?"

It can, Foster affirms. And in explaining why, he counters some of the objections raised to fixed fee schedules. The objectors, he finds, rely mainly on two arguments:

1. Some people are better able to pay than others. So fees should be tailored to a patient's economic status.

2. A rigid fee schedule "reeks too much of socialistic self-regimentation."

In the bulletin of the Los Angeles County Medical Association (which he edits), Foster replies to the first argument thus: A standardized scale doesn't prevent the doctor from *reducing* fees when circumstances warrant it. "If the patient knows . . . that his treatment should be running in the neighborhood of $150, and he sees . . . that the doctor has reduced this by $75, it makes a lasting impression . . ."

As for the second argument: "No physician," says Dr. Foster, "can legitimately complain of 'socialistic regimentation' if he has set his own price ceilings and is free to raise or lower them at any time."

He cites a recent estimate that 63 per cent of the accounts turned over to collection agencies might have been better managed by the doctors themselves if they'd made costs clear to patients at the start. A patient who knows the fee schedule is usually prepared for his final bill. So he

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Constructed of polyethylene and completely self-contained, the syringe is contamination-proof and unbreakable. Because Flo-Cillin Aqueous requires no refrigeration, the Brist-O-Matic Syringe unit can always be kept handy for emergency use. Low cost assures its practicality for one-time use, which in turn eliminates any risk of hepatitis transfer.

The BRIST-O-MATIC disposable syringe containing Flo-Cillin Aqueous is supplied as a complete unit in single sterile packages, with a choice of two dosages:

600,000 u. Procaine Penicillin G in 1 cc.

1,000,000 u. Procaine Penicillin G in 1.7 cc.

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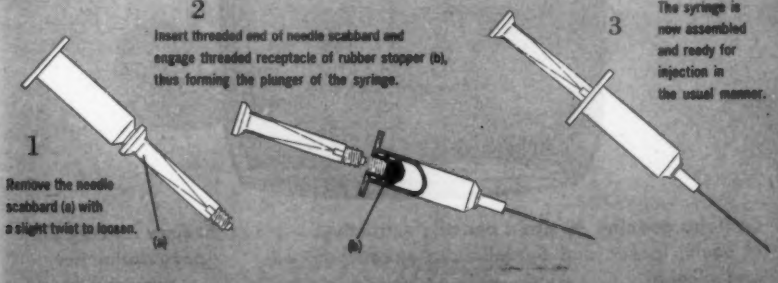
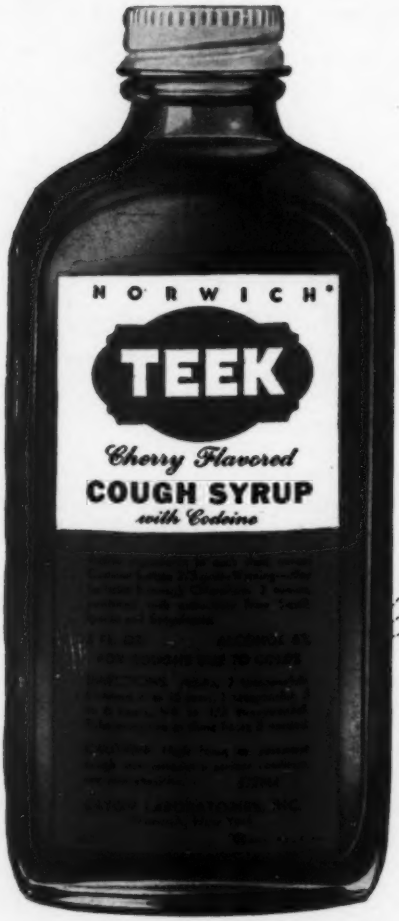


TEEK for coughs



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Exempt narcotic—prescription not required.

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seldom has reason to protest it, says Foster.

"It is an encouraging sign of the times to see such a tremendous response to the fee booklet experiment," he adds. "If just one-half of those who have indicated their interest . . . follow through with a schedule of their own . . . the idea cannot help but gain additional impetus as its worth is proved in all parts of the United States."

'Family Health Adviser' Program Spreads

More and more medical schools are offering on-the-job training in family medicine. The idea of giving medical students direct, continuous contact with family health problems—and of starting the program early—seems to be catching on all over the country.

The University of Pennsylvania's Family Health Adviser Service is already three years old. And it has paid off so richly that expansion plans are in the works. Similar training programs are being tried at such institutions as Vanderbilt and U.C.L.A. Other medical schools are mulling over the idea, says Hannah Lees, in a recent Saturday Evening Post article. And, she adds, educators from points as remote as London and Salt Lake City are converging on Philadelphia to study the U.P. system at first hand.

What these observers see is a close advisory relationship between the medical student and his assigned family. He sees them in the hospital,

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the clinic, and the home. He is assigned to them during his first year at medical school; and he stays with them until graduation.

Along the way, the student gets to learn all the problems of his family group, even though he may not medically treat them. And—most important, sponsors say—he comes in contact with such problems gradually, instead of all at once.

Current efforts to emphasize the human element in student medical training aren't the first ever made. But, says Miss Lees, prior attempts were generally made at a third or fourth-year level, "when students had often had their enthusiasm for helping people dulled by two solid years of lab work and book larnin'."

While the program has been criticized—mainly on the ground that it plunges students into deep waters before they're ready—the students themselves are apparently enthusiastic about it. As examples of how they learn by doing, Miss Lees cites some typical cases. Among them:

¶ One U.P. student called the medical school late at night. A youngster in his "family" seemed to be developing spots, he said; and he feared measles. The young man was instructed to bone up on measles while the spots ripened. This he did —and *they* did. Then, with his new knowledge, the adviser called in a general practitioner for an official diagnosis.

¶ Another student adviser was assigned to a low-income family in which the mother had high blood

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pressure. Her children were cooped up in a tiny apartment, with no safe outdoor place to play; and the children's grandfather was suffering from pernicious anemia. The student scoured the neighborhood and found a churchyard that was available as a playground. Then he talked Grandfather into undergoing treatment. With these problems off her mind, the mother's blood pressure dropped to normal.

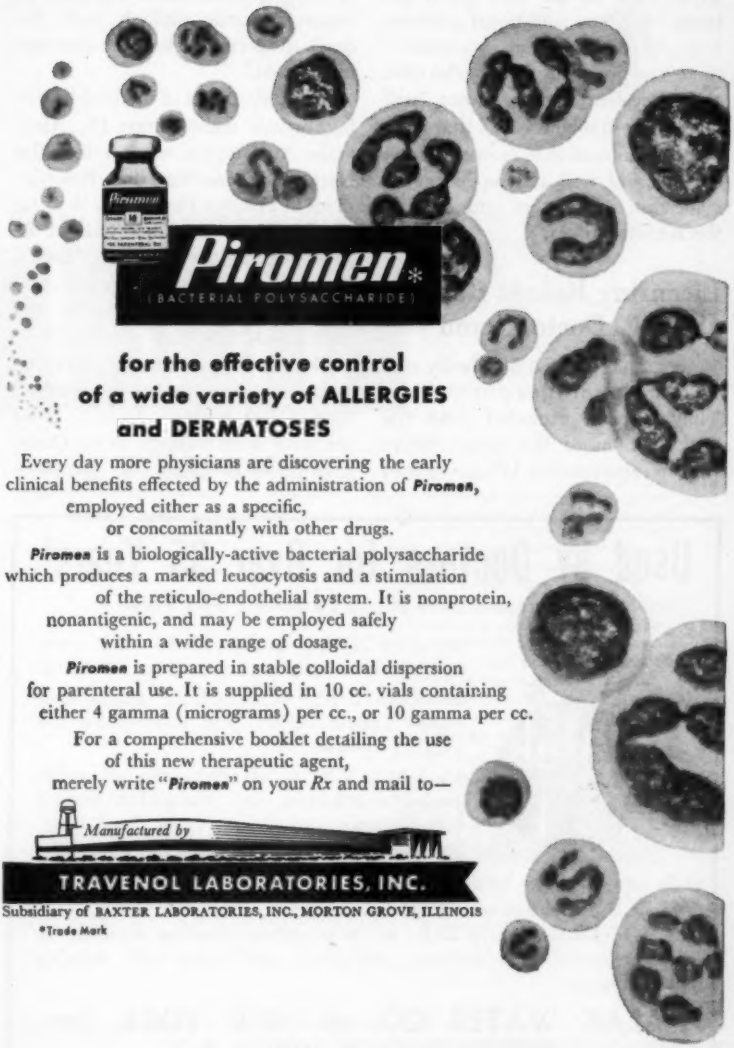
As Hannah Lees puts it, this young M.D.-in-training "might have had to practice a good many years before he learned that you could treat high blood pressure by treating someone else's pernicious anemia and getting youngsters an outdoor place to play."

British Act to Ease Load On Family Doctors

British family doctors can now look forward to easier work loads, as well as better incomes. Some months ago, they were given a retroactive pay boost of about 25 per cent. And now the maximum number of patients any one G.P. may have on his list has been reduced from 4,000 to 3,500.

What's more, an incentive arrangement encourages physicians to make still sharper cuts in their patient lists. Here's how the arrangement works, as explained by Sir James Stirling Ross of the British Ministry of Health:

General physicians are now paid flat rates of approximately $2.38 a year for each of the first 500 patients



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on their list. Then, in addition to this rate, they get a premium of $1.40 each for the next 1,000 patients. For any additional patients (up to the allowed maximum) there's no premium; just the flat rate.

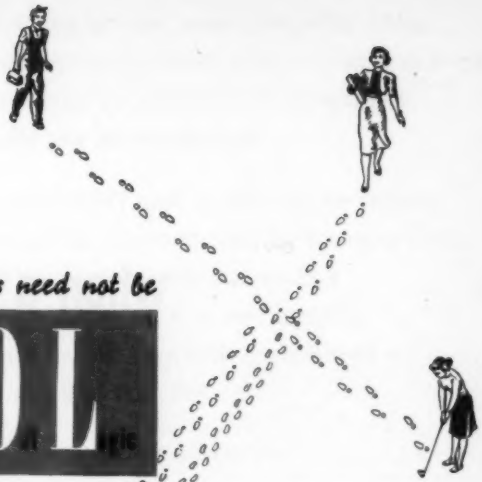
This system, says Sir James, "will discourage the heavy lists that have been an undesirable feature of the service and will recompense substantially the doctors with lists in the middle ranges."

Licensing Boards Rapped On D.P. Doctor Stand

America has given a needlessly cold welcome to refugee physicians. They've been excluded from the very sections of the nation where they're most needed. Wherever they go, D.P. medical men must face a major roadblock: "the satisfaction of the requirements of the state licensing boards—difficult and, indeed, in more than half the country, impossible."

This indictment of medical licensing boards comes from Dr. Alexander M. Burgess, chairman of the National Committee for Resettlement of Foreign Physicians. Writing in the New England Journal of Medicine, he says there is "reason to doubt the sincerity of many state boards and their devotion to the high ideals that they proclaim."

During the past several years, the Burgess committee has interviewed over 1,700 refugee doctors. Here are some of its findings, as the chairman presents them: [MORE→



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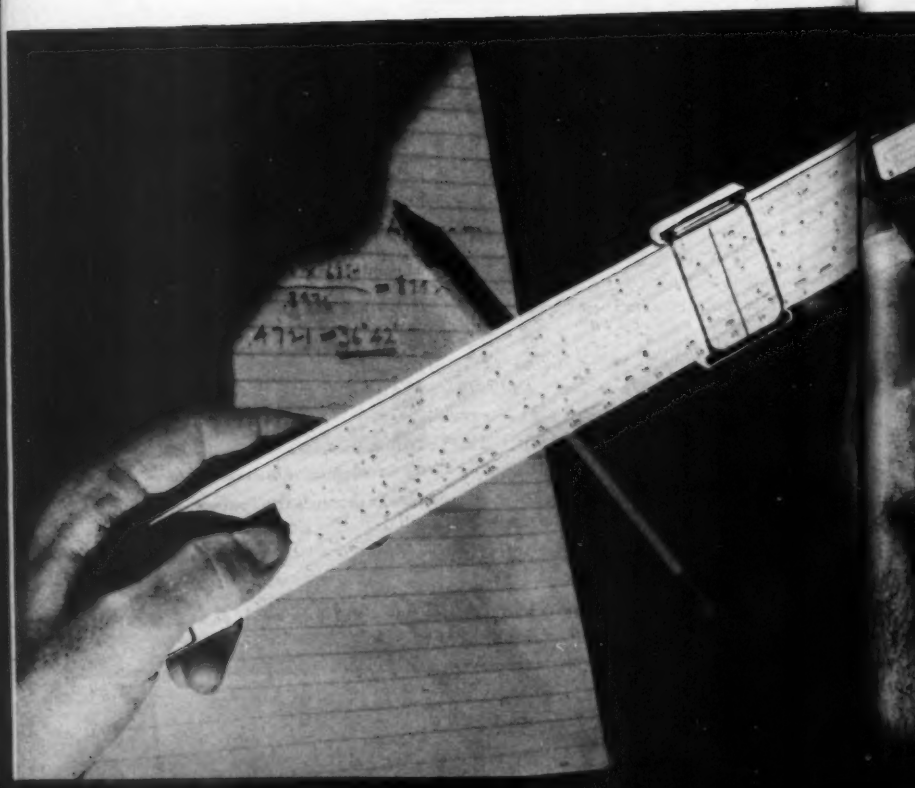

IF ENGINEERS could memorize logarithm tables, multiplication and division would for them be as simple as addition and subtraction and the slide-rule might pass into obsolescence.

IF PHYSICIANS could memorize all the pertinent prescribing information about the increasing variety of pharmaceutical products, writing a prescription would be as easy as writing your name and there would be no need for a reference book like PDR.

ed friend . . .

However, these are unlikely "ifs."

That's why engineers continue to rely on the slide-rule for help in their rapid calculations, and doctors reach for PDR—PHYSICIANS' DESK REFERENCE—when they want up-to-date information concerning pharmaceutical specialties and biologicals.

PDR

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¶ Only thirteen states and territories have licensed one or more refugee doctors. A few additional states have permitted displaced physicians to work in state hospitals.

¶ While many rural parts of the West and South complain of the doctor shortage, "it is in these very areas that the admission of the medical refugees is barred." Why? Because of a provincial distrust of foreigners and a "dog in the manger" attitude of local physicians, Dr. Burgess believes.

¶ Certain states seem to welcome the foreign doctor; but they actually disqualify him by establishing unreasonable requirements. In Massachusetts, for instance, "every foreign physician must present . . . a statement signed by the *present* dean of his medical school to the effect that he is a bonafide graduate of that school. For former students of universities now behind the iron curtain to obtain such a statement is obviously impossible." So, says Burgess, the requirement "constitutes a subterfuge to bring about the general exclusion from the state of the bulk of D.P. physicians."

He points out that the A.M.A. is on record "as urging the state licensing boards to modify their regulations," to allow for the admission into practice of the better qualified refugees. So organized medicine isn't to blame for the situation.

But precisely what standards should be employed for licensing the refugee physicians? Dr. Burgess, who has served on the board in his

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Added ounces and inches are only part of the benefit a baby derives from happy mealtimes.

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own state, Rhode Island, makes these recommendations:

1. Full citizenship should not be demanded; just first papers.

2. The physician should provide reasonable proof of his graduation from a "reputable medical school, including many not yet on the A.M.A. approved list."

3. Some additional schooling should be required of those doctors whose training—interrupted by war—was below par. New York University has established a special course for foreign-trained physicians, Burgess points out. And those who pass it are recognized by the New York licensing board.

4. One year of approved internship, residency, or fellowship should be required, or two to three years in a hospital "not on the approved list, but . . . approved by the state board."

5. The displaced physician should be expected to have "a reasonably fluent knowledge of English." Because a group of foreign doctors, hired "sight unseen," couldn't speak the language, Dr. Burgess says, one state discontinued its employment of displaced physicians in state hospitals.

6. In the case of older physicians, an oral examination should be given.

And Dr. Burgess has one final suggestion: The state licensing boards "should maintain . . . an attitude of friendship and helpfulness that would inspire confidence on the part of the newly arrived physicians in America and American ideals."


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friendly in taste — tastes like chocolate pudding—readily taken by children . . . or adults.
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Memo from the Publisher

● Some months ago, we got a telegram from an Alabama physician. One of his income-tax deductions was being challenged, and he remembered that we'd published an article giving guidance in the matter. Could we track it down for him?

We mailed him the article ("You *Can* Deduct for Entertainment"). A bit later, we heard about the results: After reading the article, the Revenue agent had rechecked with his superiors. Then he'd withdrawn his objections to the doctor's deduction.

It's not often, of course, that our tax articles are news to Revenue agents. But they *are* often news to medical men. At least that's what we deduce from readers' requests for extra copies. By this measurement, tax articles rank second only to office planning articles, among all the types we publish.

How, in a done-to-death field like tax guidance, is it possible to come up with fresh, interesting material? Perhaps you can get some idea of the answer from this case history:

"Beware of 'Simple' Tax Errors" (an article in this issue) originated with a California doctor's query. He asked us about bad-debt deductions. In the process, he mentioned that his misconceptions on the subject had brought on a full investigation of his tax return.

Should other doctors be alerted against similar mistakes? Our editors thought so. They promptly relayed the assignment to Peter S. Nagan, MEDICAL ECONOMICS' Washington correspondent, and the wheels began to turn.

Nagan first visited Internal Revenue headquarters. Talking with key officials there, he picked up a top-level slant on the common tax errors made by M.D.'s.

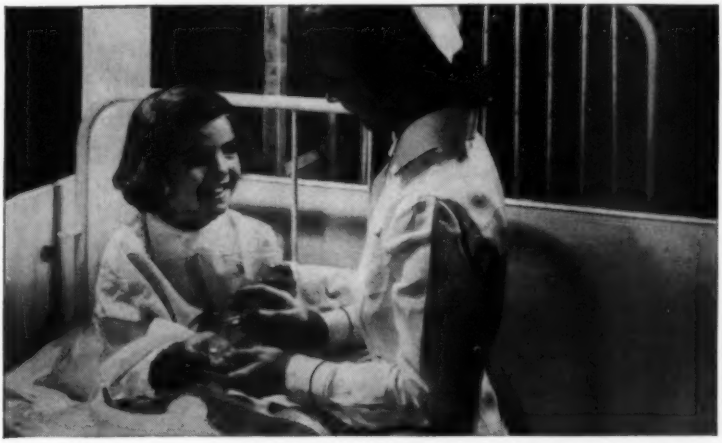
Next, he called on John C. Post, a professional management consultant. From his own experience with physicians' returns, Post supplied down-to-earth examples of simple tax errors and their consequences.

All this resulted in a Post-Nagan manuscript. After minor revamping, it was put through our editing mill. Then copies of it were checked by everyone who'd had a hand in it—as well as by other tax specialists.

You'll find the final version in this issue. What you *won't* find is a list of the people who contributed to it: three Revenue officials, three independent tax experts, four professional management men, three MEDICAL ECONOMICS editors.

That's what it takes to make a tax article both authoritative and interesting. —LANSING CHAPMAN

Four potent antibacterials offer five major advantages



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A number of hypotheses have been advanced to explain the superiority of penicillin-sulfonamide combinations. Although Bigger agrees with many other investigators that an additive antimicrobial effect may be involved, he further reasons that "If . . . the point of attack is different, such organisms as had survived the action of the first substance would become exposed to that of the second, and, if susceptible to it, would succumb."[1]

It is, of course, well known that penicillin and the sulfonamides do, in fact, attack micro-organisms in different ways. Penicillin interferes with bacterial multiplication,[2] whereas bacterial "starvation" is effected by the sulfonamides.

The many advantages of triple sulfonamide therapy are now thoroughly established.

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Children—According to weight and condition.

PENTRESAMIDE-250 is supplied in bottles of 60 and 250 tablets (slotted).
Sharp & Dohme, Philadelphia 1, Pa.

1. Bigger, J.W.: Lancet, *2*:46, 1950.
2. Herrell, W.E.: Penicillin and Other Antibiotic Agents, W.B. Saunders, Philadelphia, 1945.

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